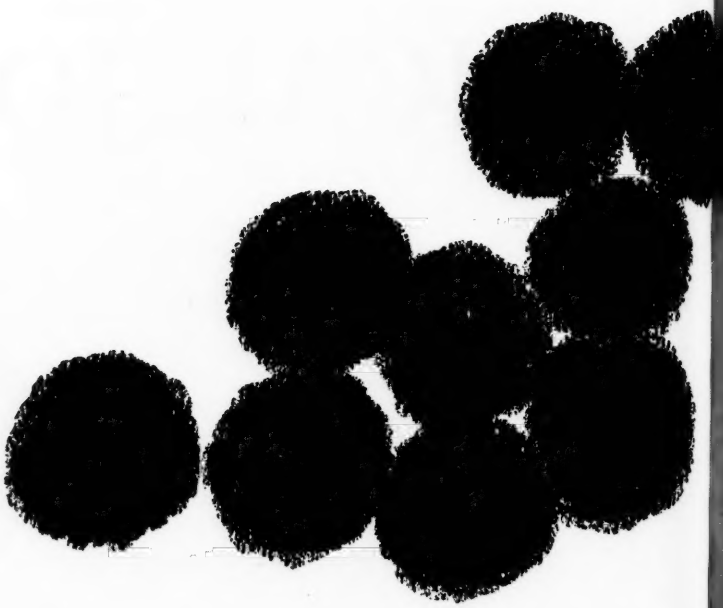
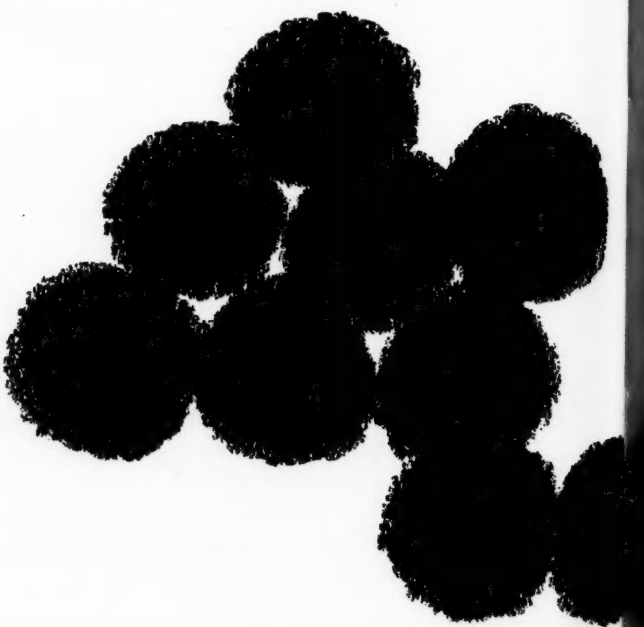
# RHODE ISLAND MEDICAL JOURNAL



MARCH, 1955



*to combat resistant bacteria...*



# The RHODE ISLAND MEDICAL JOURNAL

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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXXVIII MARCH, 1955 NO. 3

# WHAT MAKES A GOOD HOSPITAL?

ALEX M. BURGESS, SR., M.D.

The Author. *Alex M. Burgess, Sr., M.D., of Providence, Rhode Island. Commissioner, Joint Commission on Accreditation of Hospitals.*

THE ANSWER to this question can be given in two words: "Good people." Otherwise stated, it is not bricks and mortar, not edifice nor equipment, not financial backing nor public support—though all of these are important—but *people*, people who have as the first requirement adequate skill and experience, and as the second—and even more important requirement—the right spirit and intentions. From the director, manager, superintendent, or whatever the top administrative officer may be called, down to the janitors and ward maids, the entire group of individuals who make up the hospital staff must be imbued with a spirit of cooperative endeavor in carrying out what they must all realize is the basic function of the institution—skillful and kindly patient care.

Given this spirit, it will follow that the best possible equipment that can be afforded will be obtained, the best organization that the group can devise will be put into effect, and the best possible educational programs will be developed. The primary product is good care of the sick; the excellent by-products are good training of physicians, nurses and other personnel, and valuable clinical research.

The whole subject of hospitals and hospital treatment has of late become of greater importance than ever before, because present-day diagnosis and treatment of disease requires the use of equipment and techniques that ordinarily cannot be utilized except in hospitals. As a result, hospital construction is going on at an ever-increasing rate. The only solution to the problem other than the construction of more and more hospitals is the development of home care programs, whereby convalescent and slightly ill patients can be transferred to their own homes for care and follow-up by hospital staff physicians and nurses, with temporary transfer to the hospital for special tests or treatments when necessary. This type of program is being put into operation by a number of hospitals at the present time, and will, of necessity, be further developed.

With this greater demand of hospital care, it is logical that more attention be paid to the maintenance of high standards in furnishing this care to the public. As everyone is aware, the American College of Surgeons has done a great public service in carrying out a country-wide program of examination and approval of hospitals since the end of World War I. This program was taken over on December 6, 1952, by the Joint Commission on Accreditation of Hospitals. This commission is made up of representatives of the American College of Surgeons, the American College of Physicians, the American Medical Association, the American Hospital Association, and the Canadian Medical Association. Under the supervision of the director, whose office is in Chicago, field representatives supported by the member organizations visit hospitals and attempt to determine in every instance whether or not the hospital under examination measures up to the standards adopted by the commission. The "Standards for Hospital Accreditation" adopted by the commission are those developed and used by the College of Surgeons with changes and additions which the commission has made. The field representative, who is a physician, has been carefully trained in his job, and his survey of a hospital is searching and painstaking, and enables him to determine with confidence whether or not the hospital meets the standards that have been set up, and therefore is in a position to offer to the people of its community the high quality of care which they should have. The activities of these field representatives are illustrated by the following, quoted from the BULLETIN which is published bimonthly by the Director of the Commission:

"In Car 5, Seat 22, a man adjusted himself for a long train ride. Two hundred miles and five hours later, he left the train. In another half-hour, he was talking to the administrator and the medical director of a 150-bed hospital. A member of the surveying team of the Joint Commission on Accreditation of Hospitals was at work.

*continued on next page*

"By train . . . plane . . . bus . . . automobile, the representatives of the three associations which carried out the survey program of the Commission in 1953 visited hospitals through the length and breadth of our lands. They are the eyes and ears of the Joint Commission. They look and they listen. They check facilities, confer with doctors and administrators, study procedures, do all the dozens of things which make the commission program possible.

"What does it mean to be a pair of eyes and a pair of ears (and a pair of legs) for the accreditation program?

"This is what it meant last year to one surveyor. He traveled 25,225 miles by train, plane and bus. He visited fifteen states and Canadian Provinces. He surveyed forty-seven hospitals with cancer facilities and thirty-six cancer clinics and diagnostic centers. He participated in ninety-five special conferences. He was away from his home base 244 of the 365 days of 1953.

"This is a typical segment of his year (between March 18 and May 4):

"He concentrated on Florida, Alabama and Mississippi. He visited the cities of Jacksonville (twice), Gainesville, Daytona Beach, Orlando, Ocala, Tampa, Lakeland, St. Petersburg, Kissimmee, Sarasota, Miami, West Palm Beach, Fort Lauderdale, Tallahassee, Pensacola, Montgomery, Birmingham and Columbus.

"He surveyed five hospitals and twenty-five cancer facilities and attended thirty conferences. During the year, this field representative had five such itineraries, sandwiching in two special itineraries as well."

It is not my purpose to describe to you the organization of the commission nor to go into the details of the standards that it has set up. I shall, however, attempt to give you a general view of what has been accomplished and then to discuss with you certain of the standards—those which are of especial concern to the medical staff of a hospital. In the first year of its operation—the year 1953—the commission surveyed 1,306 hospitals. Of these 949 were accorded full accreditation, 204 provisional accreditation, and 141 no accreditation. It is the intention of the commission to recheck every hospital once in three years. Those which have previously received accreditation from the American College of Surgeons will retain their status until revisited by a representative of the Joint Commission.

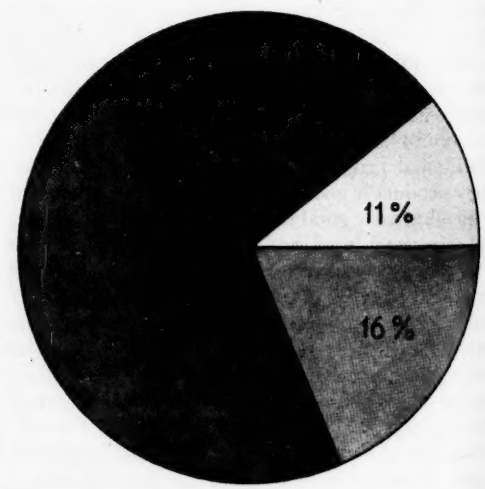
Every month each commissioner receives the report of the work of the field representatives for the previous month, with the final decision of the director as to the accreditation or non-accreditation of every hospital visited. Confirmation of these results by mail from the commissioners makes them official. In addition, each commissioner receives the list of hospitals in which the decision has been for either provisional or no accreditation with, in every instance, the deficiencies noted on which the unfavorable judgment is based. It would, perhaps, be of interest to examine the record of some of these deficiencies. They are shown in the accompanying tables, which are copied more-or-less at random from one of the recent reports of the director.

In most of these hospitals, it will be noted, the deficiencies for which criticism is made relate to staff organization and activities. In one, it is the presence of fire hazards; in another, the correction of fire hazards, and evidence of enthusiasm and ambition has resulted in the upgrading of the hospital to full accreditation. It is for others who are better qualified to speak of fire hazards, architectural defects and ineffective administration. These are important considerations and are not overlooked in hospital evaluations. For the purposes of this discussion, however, consideration will be limited to the activities of the staff, for it is almost always on the quality of these activities that the final judgment as to accreditation of the hospital depends.

**TABLE I**

ACCREDITATION STATUS OF HOSPITALS SURVEYED IN 1953

| TOTAL | Fully Accredited | Provisionally Accredited | Not Accredited | Action Deferred |
|---|---|---|---|---|
| 1295 | 949 | 204 | 141 | 1 |



## TABLE II

JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

660 Rush Street Chicago 11, Illinois

Hospital Reports Received and Scored
June 1, 1954 — July 10, 1954

The following is a list arranged alphabetically by State of hospitals which were granted:

*Provisional Accreditation, No Accreditation, Or The Surveyor's Rating Has Been Changed By The Director*

---

STATE
*City* *Name of Hospital (xx beds)* $PA^1$-$FA^2$-$NA^3$

30% Penalty Deduction:

1. Lack of review of clinical work done in the hospital.
2. Poor attendance at staff meetings.
3. Medical record deficiencies.
4. Lack of recorded consultations, particularly in sterilizations.
5. No improvement in hospital since survey of 1951.

(1)=Previous rating PA=Provisional accreditation
(2)=Surveyor's rating FA=Full accreditation
(3)=Director's rating NA=No accreditation

Before launching into a discussion which is limited to the work of the staff, I would like to mention a very important factor which is indispensable in the creation of the smoothly working, efficient organization which our hospital should be. This is the factor of cooperation between the staff, the administration and the trustees. This, experience has shown, is best achieved by the formation of a Joint Conference Committee, as it is usually called, on which these three groups are represented. Such a committee is a *must* and is specified in the standards as required in all hospitals. Where the administrator is not a physician, and in view of the fact that the trustees or governing board (or whatever may be the name of the body that is legally responsible for the operation of the hospital) is usually made up of laymen, it is especially necessary; for it is difficult for a person who is not a physician to appreciate the qualifications and experience needed in the various specialties, the facilities and equipment that is essential and the relative importance of each specialty in the over-all picture. In the same way, it is difficult for the staff physician to appreciate the problems of the administration and trustees, the necessity for careful conservation of resources, the all-important factor of public relations, etc.

Regardless, however, of whether or not the financial support of a hospital is adequate, the standards of staff organization are applicable, as for the most part they cost nothing. This is illustrated by the following quotation from an article reprinted in the little journal TRUSTEE from the May 1954 issue of HOSPITAL PROGRESS—official journal of the Catholic Hospital Association:

## TABLE III

*City* *Name of Hospital (xx beds) PA-FA-NA*

10% Penalty Deduction:

1. Obsolete by-laws, rules and regulations.
2. Inadequate staff organization.
3. Lack of recorded evidence of a thorough review of the clinical work done in the hospital.

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*City* *Name of Hospital (xx beds) NA-PA-PA*

25% Penalty Deduction:

1. Fire hazards.

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*City* *Name of Hospital (xx beds) NA-PA-PA*

10% Penalty Deduction:

1. Inadequate and obsolete by-laws.
2. Poor review of the clinical work.
3. Caesarean section rate of 11.3%.
4. Written consultations absent in many deserving cases.

---

*City* *Name of Hospital (xx beds) FA-PA-PA*

Previous fire hazards minimized, and approval from local Fire Department received.

There has been considerable improvement since survey of 1953, and the hospital as a whole is enthusiastic and ambitious. Warrants FULL ACCREDITATION with request of reports of continuous improvement.

"The most important criteria do not involve the spending of money, but rather the control of human conduct. The keeping of meaningful records does not involve any considerable outlay of capital. The work of a tissue committee presents no budget problem. Careful consultation and limitation of privileges do not call for plant expansion, but rather the intelligent and responsible use of scientific talents available. All of these are possible in any hospital—they cost no money, but they are most important as tools to improve the quality of hospital and medical care. In like manner, the establishment of a joint conference committee is easy to attain, and it can be most useful in clarifying the joint responsibility of the administration and the medical staff for good patient care."

Let us then consider the various activities of the medical staff that are essential to the conduct of a good hospital, any hospital—in fact, *every* hospital. Recognizing that in the care of the individual patient the all-important factor is the skill and faithfulness to duty of the individual physician who is in charge, there are also actions which should be taken by the whole group, the active medical staff of the hospital, by which excellent individual care can be made more effective and improvement of the whole professional environment can be brought about. The active staff is responsible for the "quality of medical care" and "the ethical standards of practice in the hospital." Besides the character and ability of the individuals who make up the staff, their organization for self-discipline and a constant check on their own work is an indispensable factor

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in maintaining these essentials. Furthermore, it is they and they only who are qualified to pass judgment on the professional ability of applicants for staff membership and to make recommendations as to the privileges and duties that should be assigned to their own members. Meetings, conferences and records which require the earnest efforts of all concerned are involved.

The active staffs of all hospitals which admit patients suffering from acute medical and surgical conditions, be they large or small, should, and according to the "Required" standards, *must* have responsible officers, adequate bylaws conforming to the requirements of the Joint Commission, and the following committees:

Executive Committee
Credentials Committee
Joint Conference Committee
Medical Records Committee
Tissue Committee

Staff meetings are essential in the interest of improvement in patient care. The requirement is specific—one meeting a month and seventy-five per cent of the active staff in attendance. In larger hospitals where the staff is divided into a number of services, these meetings may be held by the individual services, so long as a meeting of the whole staff is held every quarter. Of course, accurate attendance records must be kept, and each individual staff member must maintain an average of attendance at seventy-five per cent of the meetings, unless excused because of illness, or absence from the community, or for some similar reason. This requirement may seem too severe, but let me assure you that where the essential spirit and enthusiasm are present, proper attendance is automatic.

The function of the committees and the necessity for their existence is, I believe, clear to all. The Executive Committee, as its name implies, is empowered to act for the staff, as directed by the staff, and to carry out routine duties of coordination of the various services, receipt of reports and suggestion to the staff of new projects and developments as may require the action of the staff as a whole.

The Credentials Committee is one of great importance in which every specialty should be represented. It has the grave responsibility of passing judgment on the qualifications of those colleagues who seek appointment to the staff, as well as on all staff members in the matter of the limitation of the privileges to be accorded them in the treatment of patients. These are matters of self-discipline that must be decided carefully and conscientiously, as there is nothing more fatal to the work and reputation of a hospital and, I may add, to the patients treated therein, than the admission of incompetents to hospital staffs, and giving them a free rein in the matter of operative work and other types of patient care.

The Joint Conference Committee has already been mentioned, and the value of its work in maintaining cooperation and understanding between the medical group and the Trustees and administration has been stressed.

The value of the committees thus far mentioned is generally well understood. This, however, is not always true of the Medical Records Committee. Physicians are at times inclined to forget the prime importance to the patient, to the hospital, and to himself of a medical record that is adequate and complete. The realization of this importance is very likely to be brought home to them sooner or later—sometimes with something of a jolt—in a court of law. Not only, however, in legal matters, but also in the continued treatment of patients, or in their re-admission to the hospital, are good medical records a necessity. Again, the physician who wishes to make a case report, a clinical study or a teaching demonstration must have an accurate record from which to work. We all know these things, and yet there is no phase of our activities which in our daily hurry we are more prone to neglect. It is hard to exaggerate the importance of that group of our colleagues, whom we designate as members of this committee, whose duty it is to make us toe the mark. The Tissue Committee, acting as a constant check on the accuracy of surgical diagnosis in instances in which tissue is removed, is again an important means of self-discipline and instruction, designed to bring about a steady increase in the quality of the work of the surgical staff.

These are the committees that are required of all hospitals. In most of the larger institutions it is advisable to create others for special purposes as the need arises. Of these, perhaps the most important is the Education Committee, which has supervision of the educational program of the hospital. This committee arranges meetings, invites guest speakers, and in general has the responsibility of seeing that the members of the staff not only have an opportunity to be kept up to date by the process of educating each other, but also benefit by the opportunity to listen to speakers of wide reputation who come as invited guests. Some hospitals employ a full-time physician of wide experience and many contacts with the profession as educational director to correlate and supervise this function. When there are interns and residents, such an officer is especially important in planning and carrying on their training. A special committee to deal with the selection of interns and their education may be appropriate. Another committee of importance is the Research Committee, whose duty it is to approve and encourage all research projects from simple case reports to the most elaborate investigations. Even in small hospitals where the opportunities for re-

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# RECENT ADVANCES IN THE MANAGEMENT OF SEVERE AND EXTENSIVE BURNS

BERT S. JEREMIAH, M.D.

The Author. *Bert S. Jeremiah, M.D.; Plastic Surgeon, The Memorial Hospital, Pawtucket, Rhode Island; Consultant in Plastic and Reconstructive Surgery, Roger Williams General Hospital, Providence, Rhode Island.*

SINCE the Second World War, many changes and much progress has been made in the treatment of burns. The major conflagrations that frequently occur result in large numbers of thermal injuries, and even now severe thermal catastrophes are anticipated in the future with the greater use of atomic energy. For these reasons, new and better methods are constantly being formulated to better cope with the atomic bomb victims, which may be in the thousands within a single city of the United States. In the past ten years, the mortality of severely burned patients has diminished considerably due to improved methods of skin grafting, early operations and better medical treatment.

At present in the United States, we have yearly approximately nine thousand deaths from burns of all types. We are striving constantly to reduce this high mortality rate by proper management of the patient with severe and extensive burns. It has been estimated that during peace time eighty-three per cent of all burns occur in the home, ten per cent in industry and seven per cent in public accidents. Careful medical supervision is essential in attempting to maintain normal physiochemical levels. The plastic surgeon is frequently called upon to handle a burned patient from the very beginning on the basis that eventually the reparative work will have to be done by him.

In the treatment of a severely burned patient, it is important to note that the systemic changes are of greater importance than the local therapy. If a patient is seen at the scene of the injury, a quarter or a half of a grain of morphine sulfate is given and the patient is immediately hospitalized. At the hospital, additional morphine may have to be given in order to control the severe and excruciating pain. Tetanus antitoxin and gas gangrene serum are given in some cases. We are also accustomed to giving twenty-five milligrams of ACTH which helps to prevent shock, reduces the intensity of pain and gives the patient a state of euphoria. In addition, six hundred thousand units of penicillin is given intramuscularly and repeated every twelve hours. The use of tannic acid and gentian violet has been discontinued in the better and more progressive hospitals and clinics, chiefly because of the suppuration hidden beneath the well-formed coagulum. Pyruvic acid has been abandoned also because of the excruciating pain that it so often produces.

The closed pressure method of treating burns was used extensively on the victims of the Cocoanut Grove disaster at the Massachusetts General Hospital a few years ago. More recently, the local use of the sulfonamides, either in powder or in ointment form, was widely used during World War II, but has now been abandoned because of the renal complications and many other systemic reactions which apparently resulted from unpredictable absorption.

Today, the most commonly used materials for the immediate local covering of the burned area are autoclaved gauze or rayon strips impregnated with furacin or vaseline. On infected or potentially infected areas, isotonic saline wet dressings are used either directly over the dressing or through fenestrated catheters. The preparations enumerated are not ideal, but are superior to the hundreds of proprietary ointments and other products that are on the market today.

If there is evidence of infection, we use wet dressings consisting principally of isotonic saline with two hundred fifty units of penicillin per c.c.

**Fig. 1. Closed pressure dressing with multiple fenestrated catheters and Reynolds aluminum foil beneath ace bandage.**

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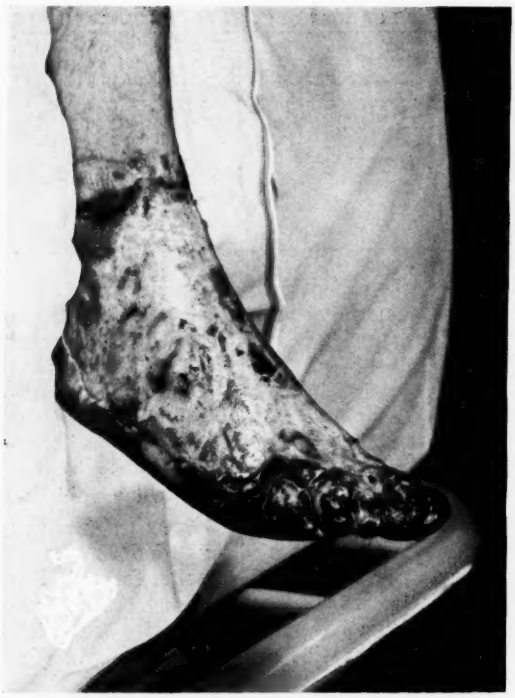

**Fig. 2. Third degree burn of the entire foot treated with Tryptar and grafted thirteen days after the initial injury.**

**Fig. 3. Split graft applied on dorsum of foot. Note few sutures and fenestrations of graft to prevent accumulation of serum or hematoma.**

of saline. The dressing is maintained moist through fenestrated catheters spaced at various intervals of a burned area. If pyocyanea has been demonstrated by cultures, we alternate with one-fourth per cent acetic acid in normal saline solution.

There is considerable time consumed with each dressing. Heavy sedation of the patient is preferable with each dressing and avoidance of repeated general anesthesia as it increases shock and diminishes resistance to infection. We have used intravenous surital to the point of analgesia during secondary dressings and even for grafting where no suturing of the grafts was indicated.

The care of even one severely burned patient is too much for the average physician or surgeon unless he has adequate experienced help to aid him. All the dressings should be done in the operating room under aseptic conditions with the patient sufficiently sedated. After the dressing is removed, cultures are taken to determine the predominant microorganism present. Any loose debris or slough is removed. No attempt is made in the initial dressing to remove dirt particles either by debridement or rubbing and scrubbing of the involved area. A gentle saline wash may be harmless but rubbing vigorously to remove imbedded and firmly adherent dirt particles will cause considerable disturbance of the existing epithelium. This will also greatly increase the depth and extent of the burn.

In applying the dressing, all the layers of the dressing including the impregnated furacin gauze are placed in a longitudinal manner except that of the outer layer which consists of the stockinettes or elastic bandages. If we wish to retain our solution within the dressing and prevent it from saturating through to the outside elastic bandage, we employ Reynolds heavy duty aluminum foil. This gives a continuous wet dressing that is often desirable during the warm months or when the humidity is high. The success of the wet dressing, either in the ungrafted or grafted case, depends on keeping it constantly and thoroughly saturated with the solution employed. An inadequate amount of the solution may defeat the entire purpose of the dressing. Excessive quantities of the solution employed (isotonic saline with penicillin) do no harm in our experience. The amount of the solution required will vary greatly. This will depend and vary with the temperature or humidity of the environment where the patient is confined. We have used as much as four ounces of the solution injected into each catheter every two hours, day and night. On the order sheet, it is very important to impress all the attending nursing personnel that the dressing be kept constantly and thoroughly saturated with fluid and that no harm can come from any surplus amounts.

We have frequently used tryptar to speed up demarcation and debridement of the third degree burns. The application of tryptar may be tried after the first dressing. A few days later, demarcation will be completed and the slough can be removed either by the Ferris-Smith blade or by means of the Padgett's electric dermatone. Either immediately or a few days later, the area may be skin grafted depending on the presence or absence of infection.

For the preservation of function; position is most important, particularly, of the hands and feet. The knee and elbow joints should be dressed in the extended position and the feet should be protected to avoid foot drop. Elevation of the upper and lower extremities is essential particularly during the healing period so as to encourage lymphatic drainage. Deep burns of the dorsum of the hands must be grafted very early, within a week if possible. If not, necrosis will develop, joints will be exposed and there will also be tendon fixation with fibrosis and

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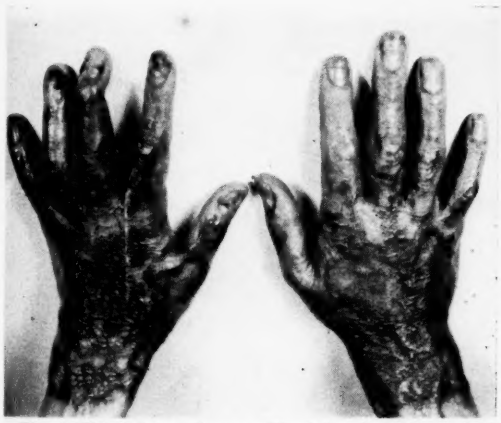

**Fig. 4. Third degree burns of both hands with marked scar formation.**

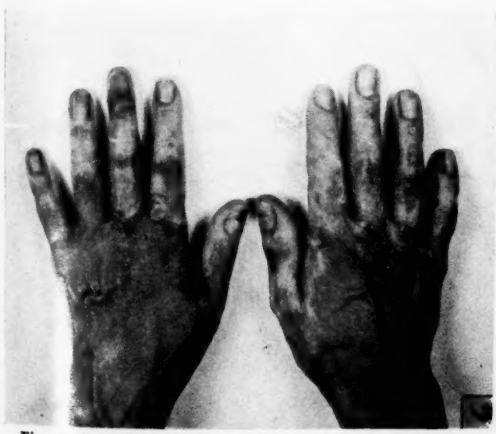

**Fig. 5. Complete excision of superficial and deep scar followed by application of heavy split graft; one year postoperatively.**

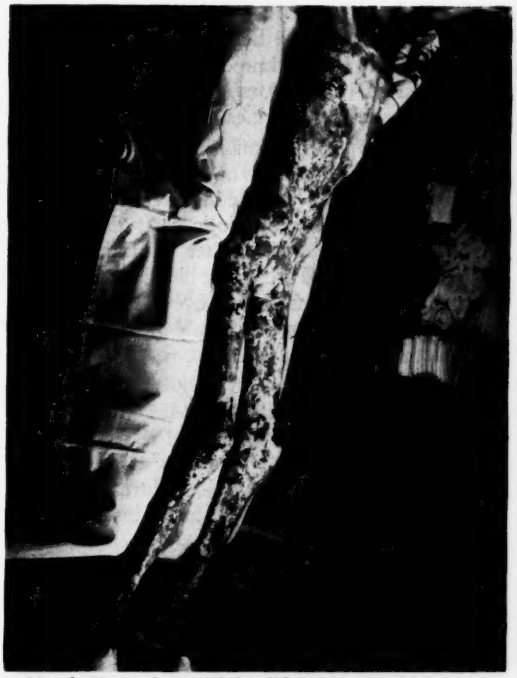

**Fig. 6. Circumferential third degree burns of the lower extremities and trunk including buttocks and external genitalia.**

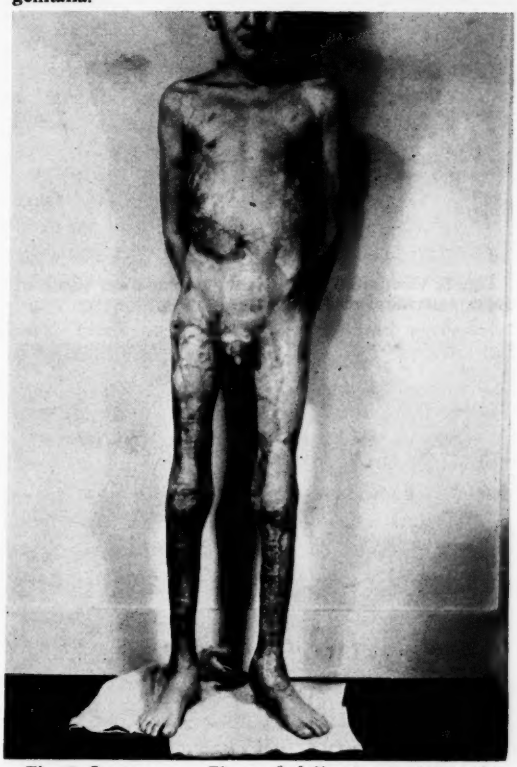

**Fig. 7. Same case as Figure 6, following multiple skin grafts.**

deep scarring. Debridement particularly on the hands may be hastened by removing the necrotic tissue and skin grafting immediately. Sheets of skin grafts are used on the dorsum of the hands which extend to the midlateral lines of the fingers.

If considerable infection is present during the debridement, wet dressings or impregnated furacin autoclaved gauze may be used to prepare the recipient area. The specific antibiotic must also be used as indicated by cultures. Other helpful adjuncts that must be included are whole blood, plasma, high protein diet, vitamins and above all sympathetic encouragement to help the morale of the depressed and severely burned patient.

Blood transfusions must be given freely. One must not wait until the patient becomes anemic. Anemia develops very rapidly and is the result of destruction of the red blood cells at the burned areas, and also due to loss of blood during and with each dressing which sometimes has to be done every day.

The use of plasma as an initial replacement of fluids in severe thermal burns is not as efficacious as whole blood transfusions. In extensive third degree burns, we have given from one to two liters during the first twelve hours. This amount is regulated by the degree of shock present. Plasma is lost because of the increased capillary permeability. The simplest method to determine the amount of plasma needed in an acute burn case is to give one hundred c.c. of plasma for every point the hematocrit is above normal. If the patient is conscious, he is encouraged to drink large quantities of bicarbonate saline solution. The evaluation of the patient's condition is on the basis of temperature, pulse, blood pressure, urinary volume, specific gravity, red blood count, hemoglobin and the hematocrit. If the hematocrit is fifty or above, the patient's condition appears grave, blood transfusions should be continued until there is evidence of subsidence of shock. When shock is well under control, blood is given in five hundred c.c. amounts daily or every

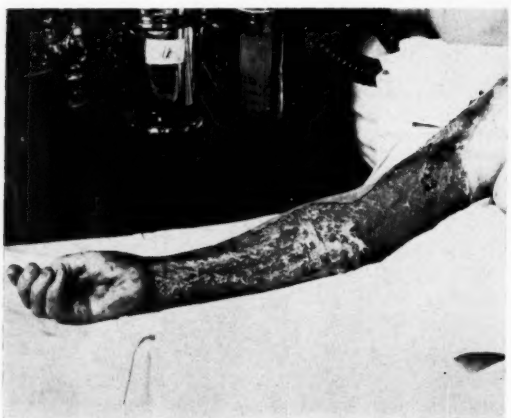

**Fig. 8. Circumferential healthy granulation tissue of upper extremity; ready for skin grafting.**

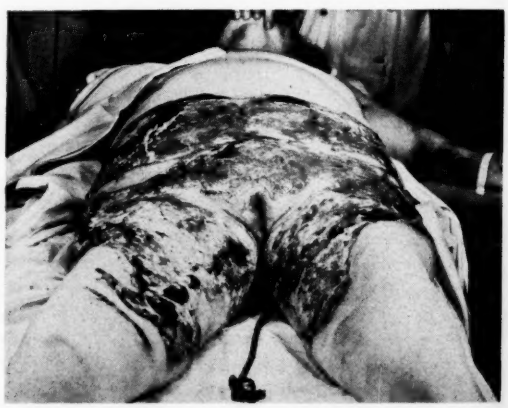

**Fig. 10. Third degree burn involving entire abdomen, perineal region, both thighs and right upper extremity of a seventy-three year old woman; treated locally with furacin autoclaved gauze.**

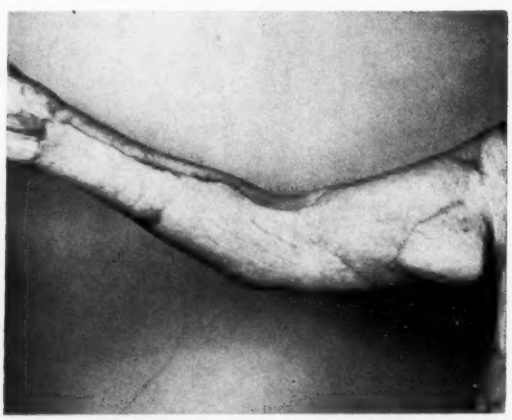

**Fig. 9. Same extremity as Figure 8, following skin grafting; two months postoperatively.**

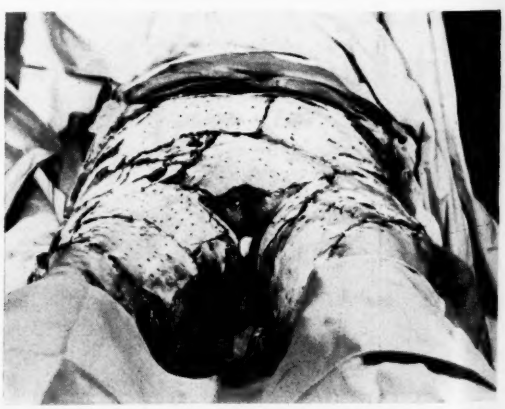

**Fig. 11. Application of large sheets of pie-cut grafts. Fixation accomplished with topical thrombin and plasma.**

two days in an effort to prevent anemia. Do not allow anemia to develop. It is a dangerous sign in a severely burned patient.

If acute renal insufficiency occurs, conservative methods should be used in the treatment; limit the fluid intake to urinary output plus adequate allowance for insensible water loss. To combat negative nitrogen balance in the extremely burned patient, one must administer proteins in amounts far in excess of normal individual requirements in addition to the multiple transfusions of the whole blood which may be indicated.

The use of homographs has greatly helped the extensively burned patient. It is very important to convert the necrotic wound into a closed wound. Homographs are used when not enough of the patient's own skin is available. In these cases homographs must be employed. The maximum survival time has been reported by some authors to be eight weeks. The use of cortisone and ACTH in our experience has not helped to promote and stimulate permanent survival. We have observed in the cases treated by us, that if the homographs used are of the same blood grouping as the patient, the survival period is much longer. We have no explanation to offer for this but the problem of homographs is now under intensive consideration and investigation.

The usefulness of ACTH and cortisone is controversial in the treatment of extensive burns. Some believe that ACTH is an indispensable drug in the treatment of severe burns. We do not believe this to be so. The only important changes we have noted when ACTH was used is slight diminution of pain and a mild state of euphoria. ACTH does not have any stimulatory effect on spontaneous epithelialization as was previously believed. We have not seen a higher percentage of grafts take because of the use of ACTH or cortisone. The degree of high take in a grafted area is determined by many other factors such as healthy granulation, absence of infection, immobilization of the areas grafted, prevention of hematoma which may undermine the grafts, and the use of antibiotics.

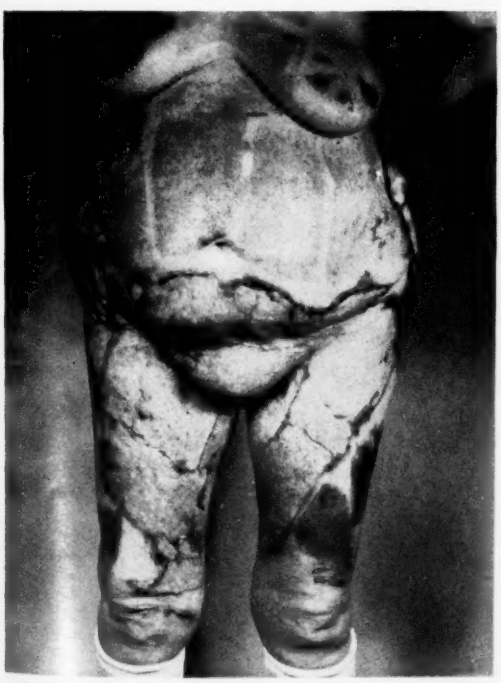

**Fig. 12. Note excellent take of grafts with minimal scarring.**

To combat infection, one must employ the most rigid sterile precautions in the initial and all of the subsequent dressings. Frequent cultures should be taken and appropriate antibiotics should be used. Wet dressings should not be overlooked whenever they are needed.

Our primary aim in the severely burned patient is early and complete coverage of the granulating surfaces so as to prevent loss of electrolytes, proteins and to avoid scarring and severe contractures. In severe burn cases, cosmetic considerations are entirely unimportant and are sacrificed. These are later or delayed problems and are undertaken after complete coverage and healing has taken place. The grafts may be cut with a dermatone and as thin as possible since thin grafts have a better chance for survival. If the donor area is limited as in cases where fifty per cent or more of the body is burned, the same donor area may be used two or three times at intervals of four to six weeks. We had a case which sustained seventy-five per cent third degree burns of the body, this included both lower extremities, external genitalia, buttocks, abdomen, chest up to the nipple line anteriorly, and to the level of the inferior border of the scapula posteriorly. The only available donor areas to be used were both upper extremities and upper third of the chest and back. These areas were used on four successive occasions with good results.

Recently, an acute revival of an old method has been employed, namely the open or exposed method of treatment. This method is based on common knowledge that bacteria are subject to various external influences in their growth. Such external influences have proved to be moisture, atmosphere, temperature, light and even chemicals. It is an established fact that room temperature is less favorable to the growth of bacteria than body temperature. It has also been found that certain factors are unfavorable to the growth and multiplication of pathogenic bacteria. These factors are exposure to light, lack of moisture and a temperature below that of the body. Upon these factors the exposed method of treatment is based. This method should

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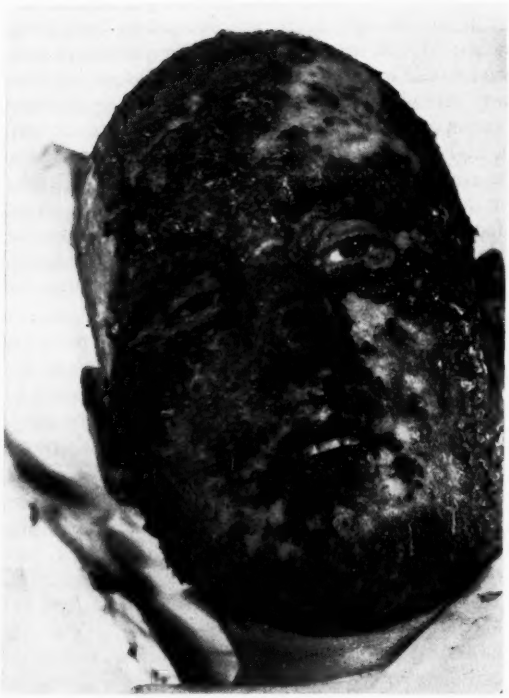

Fig. 13. Second and third degree burns of the entire face using the exposed method.

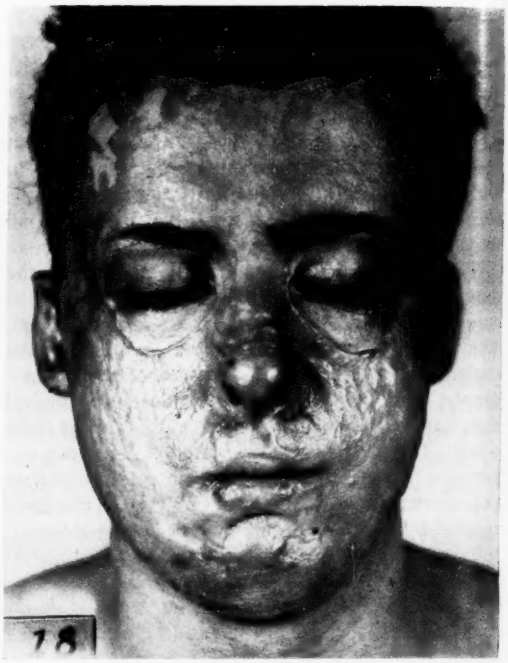

Fig. 14. Same patient as Figure 13 following complete healing. Wolfe grafts to both lower lids.

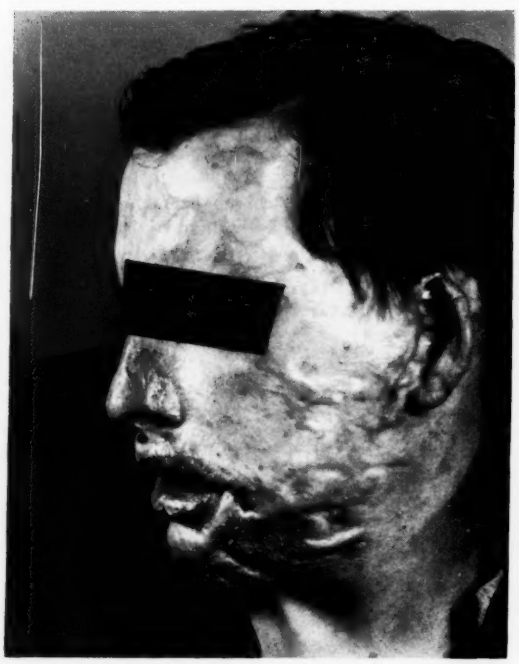

Fig. 15. Severe scarring of face secondary to thermal burn.

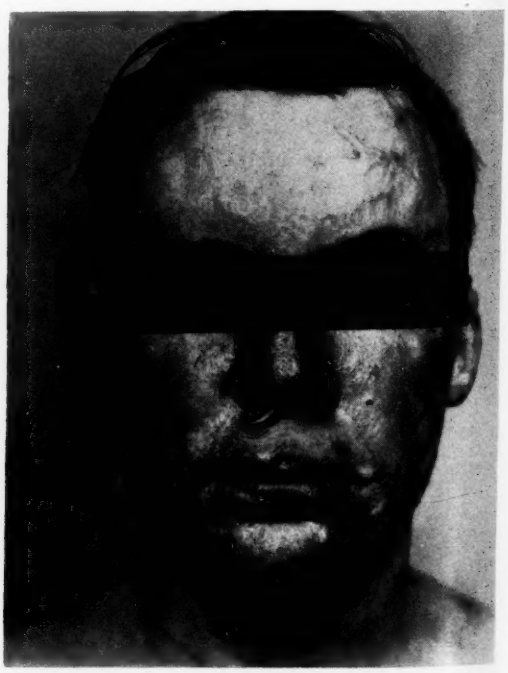

Fig. 16. Same patient as Figure 15 following excision of scars.

have wide clinical trials at the hands of many operators. The method has obviously been on trial for too short a period to frame definite conclusions.

The Newport Naval Hospital at Newport, Rhode Island, has applied this method for the first time on a large scale during the Bennington Disaster. It is now too early to become enthusiastic over the merits of this method. Furthermore, the open air method of treating burns is not applicable in the large deep circular burns of the lower extremities and trunk. It is definitely contraindicated in patients with old chronic burns, since experience has proven that all raw granulating surfaces cannot be exposed to the air without protection. This method has not by any means reduced the mortality rate in severe burns.

Our method of treatment has been the closed pressure dressing method. The chief therapeutic importance of this method cannot be underestimated. The main function of the pressure dressing is probably immobilization, thus minimizing pain, protects against further injury, infection and also against the loss of fluids such as lymph and plasma. During the entire treatment of the burned patient, we must be kind. The morale of the patient must constantly be maintained to the highest possible level. The patient should not be overlooked during rounds. He should be seen by all the members of the staff during rounds, even though he may be in his second or third month of hospitalization. His case must be discussed like any other case. Attempts should be made to early ambulate the patient. In addition, some form of occupational therapy should be instituted as soon as possible, especially when the hands and feet are involved.

Certain complications may arise following the treatment of severely burned patients. These complications may be outlined as follows: Cicatricial contractures, superficial and deep scars, keloid formation and late malignant changes of the ungrafted scar tissue.

Contractures are the end result of a long continued granulated surface which has remained unhealed and uncovered with skin. The avoidance of contractures depends mainly in overcoming scar formation. This means early skin grafting and avoidance of infection. The longer the healing is delayed the heavier and thicker will be the scar. Here we must emphasize that the Reverdin ("pinch") grafts have no place in reconstruction work. They do not prevent scar formation nor do they control its contraction during the healing process. The cosmic results on both the recipient and donor areas is very undesirable. Large doses of ascorbic acid, aid in healing and in minimizing scarring. If there is a small residual scar which has failed to disappear and it presents itself in a very conspicuous area such as the face, it may be excised or abraded by means of autoclaved sandpaper or by Kurtin's planing method.

Keloids and hypertrophic scars are the second most important complication which may occur following a severe burn. A distinction is often made between hypertrophic scar and keloid. The former is excessive production of fibrous tissue within the limits of the wound, while the latter is exactly the same process in the wound, plus a similar invasion and spreading into the surrounding skin. The keloid may attain tremendous thickness and it is persistent while the hypertrophic scar is usually self-limited in duration and gradually disappears in the course of a few months.

There are about three definite conditions which increase the tendency to keloid formation. The first and probably the most common is prolonged infection of granulation tissue. The second are burns by acids. These are very prone to form a heavy scar or keloid. The third influence for the formation of keloids is racial. They are more common in the Negro, Chinese and Japanese as compared to the white race. The management of keloids are too numerous to mention. We have had the best results by excision and skin grafting or excision followed by x-ray therapy soon after the sutures have been removed. Even the grafted area can tolerate small doses of X ray without doing any damage to the graft.

Carcinomas occur very frequently in old burned cases particularly those associated with marked sclerosis and frequent occurring ulcers. In our short

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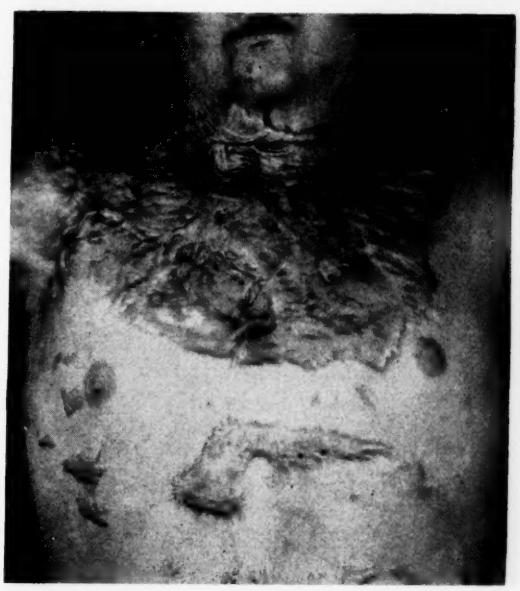

**Fig. 17. Extensive keloid formation secondary to thermal burns, involving neck and chest.**

experience of treating burns for the past ten years, both in the Army and in civilian life, we have had ten cases of carcinoma develop in patients. These were on the hands, lower extremities and one in the left inguinal region. The treatment of these cases consisted of wide excision and skin grafting.

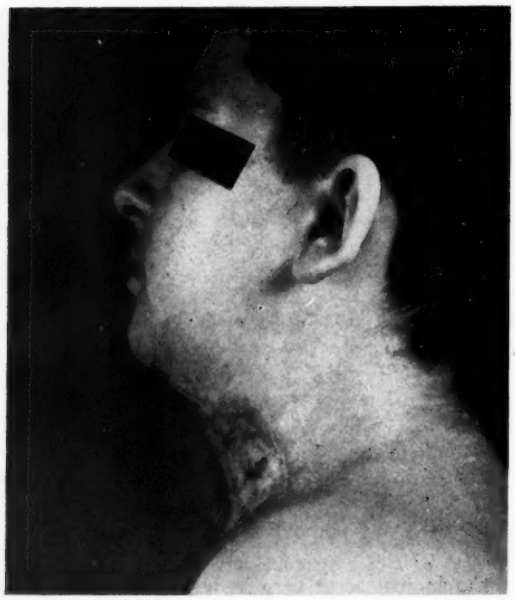

**Fig. 18. Excision of keloid of neck and application of heavy split graft; ten days postoperatively.**

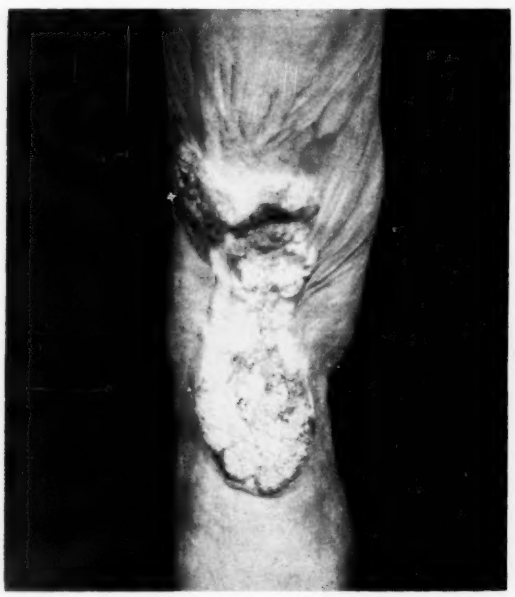

**Fig. 19. Extensive basal cell carcinoma of the popliteal space secondary to an old thermal burn.**

## SUMMARY

The numerous mechanical and chemical advances made in industry and at home have stimulated us to more adequate and intensive treatment for severe burns. The object of the treatment is the same as that of other trauma. The treatment of shock is our first consideration. The local wound is then protected from mechanical injury and pathogenic bacteria. Our method of treatment has consisted of gentle cleansing followed by compression dressings into which fenestrated catheters have been incorporated. Debridement has often been hastened by the use of Tryptar. This has always been used after the first dressing. ACTH and cortisone have been used but without any outstanding results as an epithelium stimulator. They do, however, help to minimize pain and produce a state of euphoria. The main objective in the treatment of burns is to minimize early contamination, prevent infection, promote drainage of the burned wound, immobilization of the burned part so as to prevent loss of serum and secure rapid and early healing with a minimal loss of function.

We prefer the closed pressure dressing method in the treatment of burns particularly the circumferential burns and burns of the hands. The exposed method of treatment may be used in massive burns such as might occur in severe explosions or in atomic bomb explosions. This method has shown promise and in the future may prove desirable.

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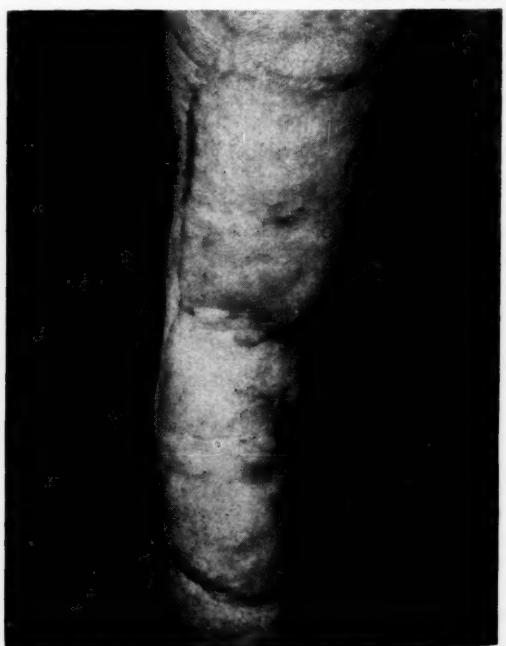

**Fig. 20. Same patient as in Figure 19 following radical excision and application of split grafts; five years postoperatively.**

# The RHODE ISLAND MEDICAL JOURNAL

*Owned and Published Monthly by the Rhode Island Medical Society*
*106 Francis Street, Providence, Rhode Island*




## IN MEMORIAM — DR. JOSEPH C. O'CONNELL

TO HAVE BEGUN one's chosen career in the vigor of youth as a general practitioner, and to have ended it at the summit of surgery; to have grown in knowledge, skill and wisdom during the most extraordinary period of progress that medicine has ever seen; to have expended this knowledge, skill and wisdom in the service of one's fellowmen, without distinction of poverty or riches, race, creed or social position; to have responded gladly at all hours of the day or night to the summons for help, with total disregard of personal convenience or fatigue; to have brought solace when one could not bring cure to the bedside of the sick; to have taken time out of one's busy life to further many causes without the ambit of one's profession; to have merited and retained the tribute of gratitude from hundreds of devoted patients; to have been an inspiring leader in the effort to lighten the financial burden of illness; to have died in the full bloom of one's powers, still actively engaged in the practice of one's profession, respected and revered by one's colleagues and a host of other friends — all of these things were accomplished by Dr. O'Connell in the more than fifty years of his medical career. He will be missed by all of us; and the memory of his honorable life and splendid example will surely find an abiding place in the noble company of beloved physicians.

*Requiescat in pace.*

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## MINNESOTA AND DISABILITY INSURANCE

Minnesota is the latest state to file a comprehensive report on the question of whether a compulsory sickness and disability insurance program is a necessity. The findings in Minnesota resulted in the recommendation that no legislation be adopted, and as we read the comprehensive study undertaken by the study commission, including its first-hand appraisal of the plans in Rhode Island, New York and New Jersey, we were struck by the fact that the honor of pioneering this type of legislation has penalized our State in no small measure.

Minnesota, for example, followed in some measure the type of study made in Massachusetts several years ago, whereby the need for cash sickness compensation as a compulsory legislative program was thoroughly explored. As the Minnesota report states, "there has not been presented any picture of economic distress which the people of the state are unable to solve for themselves. Exactly the opposite has been demonstrated, and that is, that under voluntary freedom of action, in those areas where the need or the desire for the same has been existent, tremendous coverage has been rapidly developed by employers and employees joining in the arrangement for the purchase of sickness insurance, paid sick leave, or some similar plan."

The Minnesotans also took time to consider the seriousness of adding new taxes that might penalize industry, particularly new businesses considering locations in their state. We in Rhode Island have been made very conscious of our failure to consider this factor, and in recent years we have taken belated steps to halt the transfer of industries from our confines.

Recognition is also given to the trend of the past decade for industry to work out on a voluntary basis effective programs to assist its workers with satisfactory sick leave plans, and the report notes that "experience would indicate that as soon as industry or business in a state is established and making a profit over a reasonable period of time the pronounced trend is to voluntarily arrange a plan of insurance." We have seen a remarkable support by industry of Blue Cross and Physicians Service in Rhode Island, and we are prompted to think that undoubtedly temporary disability compensation would also have been provided without the far from satisfactory compulsory setup that was "presented" to the workers of the state in 1942 at their own expense.

We conclude with concurrence in the statement of the Minnesota group as being equally applicable to the citizens of Rhode Island when they state "We believe the standard of living and the ability of the people of this state to meet their problems in the face of sickness and accident under free enterprise is equal to or better than most states who have not deemed it necessary to enact such legislation."

## FIVE YEARS' EXPERIENCE

In this issue we have published the address by the President of the Rhode Island Medical Society Physicians Service on the occasion of the annual corporation meeting, this time celebrating the completion of five years' service in the voluntary surgical-medical insurance field in Rhode Island. The healthy growth noted in the enrollment and support of the program is a source of encouragement to all of us as we seek to further our aims to extend the insurance method of prepaying for catastrophic illnesses.

Of particular interest, however, is the long range planning and thinking now advanced, and as set forth by Doctor O'Connell in his remarks to the corporation, for major medical expense protection that would start when either the hospital benefits or our Physicians Service benefits have been expended under our existing programs. The emphasis until now has been on the development of what has been for the most part indemnity for the cost of surgical procedures. The new plan would seek to indemnify for the long term illness or accident that can result in bills far in excess of the benefits provided by ordinary insurance contracts.

For example, the major medical expense type of protection already developed in some areas of the country provides maximum benefits up to $5,000, over and above the base benefits now provided by Blue Cross and Blue Shield plans. With this type of coverage the subscriber accepts the responsibility, on his own or through his present insurance coverage, for bills anywhere from $100 to $500, and when his costs for ill health go beyond those indemnities his major medical expense contract would be effective, paying 75% of all subsequent bills up to the five thousand dollar maximum.

As all the voluntary insurance groups have learned, the public is anxious now more than ever before to accept the responsibility of prepaying for hospital and medical care expense. The education has moved fast in the past decade as regards the importance of coping with personal ill health expenses, and in the next decade it is to be hoped the expansion now being contemplated may be fully realized. A comprehensive medical care insurance program must be eventually developed on a voluntary basis; it will never be as effective and satisfactory if it is foisted on the people through compulsory regulations.

## ACCREDITATION OF HOSPITALS

From the end of World War I until 1952 the American College of Surgeons performed an outstanding public service in maintaining a nation-wide program of examination and approval of American

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PRO-BANTHĪNE® FOR ANTICHOLINERGIC ACTION

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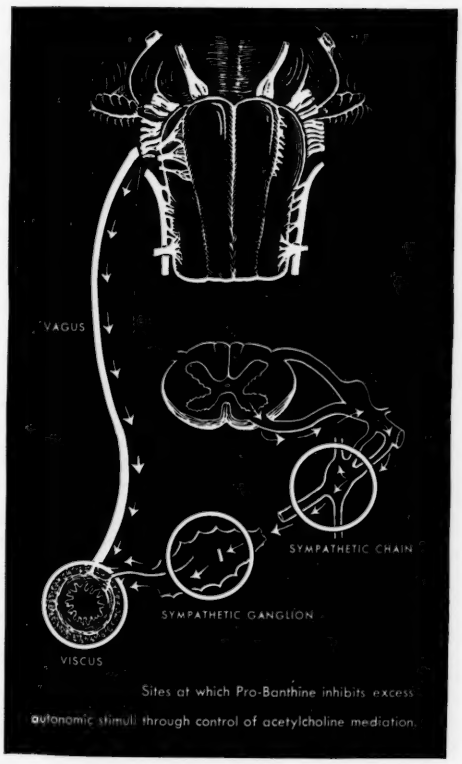


Sites at which Pro-Banthine inhibits excess autonomic stimuli through control of acetylcholine mediation.

Roback and Beal[2] found that Pro-Banthine orally was an "inhibitor of spontaneous and histamine-stimulated gastric secretion" which "resulted in marked and prolonged inhibition of the motility of the stomach, jejunum, and colon. . . ."

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In Roback and Beal's[2] series "Side effects were almost entirely absent in single doses of 30 or 40 mg. . . ."

Pro-Banthine (β-diisopropylaminoethyl xanthene-9-carboxylate methobromide, brand of propantheline bromide) is available in three dosage forms: sugar-coated tablets of 15 mg.; sugar-coated tablets of 15 mg. of Pro-Banthine with 15 mg. of phenobarbital, for use when anxiety and tension are complicating factors; ampuls of 30 mg., for more rapid effects and in instances when oral medication is impractical or impossible.

For the average patient one tablet of Pro-Banthine (15 mg.) with each meal and two tablets (30 mg.) at bedtime will be adequate. G. D. Searle & Co., Research in the Service of Medicine.

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1. Schwartz I. R.; Lehman, E.; Ostrove, R., and Seibel, J. M.: Gastroenterology *25*:416 (Nov.) 1953.
2. Roback, R. A., and Beal, J. M.: Gastroenterology *25*:24 (Sept.) 1953.

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## ACCREDITATION OF HOSPITALS

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and Canadian hospitals. The ever increasing hospital expansion following World War II, the development of Blue Cross hospital insurance plans, and the general education of the public in health care put a further burden on the surgical society to continue its work of accrediting hospitals.

Late in 1952 a Joint Commission on Accreditation of Hospitals was established, consisting of representatives of the College of Surgeons, the College of Physicians, the American Medical and Hospital Associations, and the Canadian Medical Association. Named to that Commission as one of the representatives of the American College of Physicians was our Doctor Alex M. Burgess, Sr., of Providence, whose career in medicine needs no elaboration here for our membership.

The JOURNAL is pleased to print in this issue a discussion of the work of the Joint Commission by Doctor Burgess, together with a keen analysis by him of the factors that make for a good hospital.

## COMMON SENSE SHOULD PREVAIL

In the past two decades we have witnessed a tremendous development of bureaucracy in our federal government. As a result any attempt to take sensible action to eliminate any program that a federal agency has developed meets with violent opposition from the agency and its particular beneficiaries.

The Defense Department announced that it will shut down the Murphy General hospital, a veterans hospital in Waltham, as an economy measure since the hospital has a small case load. Immediately the pressure was released on the congressional delegation from this area to oppose the economy action, and even though only 101 of the 431 beds in the hospital are being utilized the bureaucrats insist, with the vocal aid of some of their supporters, that the expensive establishment remain in operation.

We commend THE CALL, the excellent daily newspaper published in Woonsocket, for its forthright editorial stand expressed last month on this problem. Said THE CALL:

> "Final decision on whether or not to close Murphy Hospital should be based strictly on facts. The decision should be made on costs, need, number of patients and availability of other facilities. Emotion should play no part in it. Talk of the action being a 'slap in the face' to the New England congressional delegation is just so much poppycock. . . . Common sense and not politics should decide whether or not to close the Murphy Army Hospital on June 30."

The same kind of common sense should be employed in the appraisal of the veterans hospital expansion throughout the country.

## THE R. I. MEDICAL JOURNAL

A decent respect for the opinions of mankind and a very natural desire to hear nice things said about us have led us to insert here the letter which we have recently received. We are greatly pleased. Also, we want to record here our appreciation of this nice lady, who even at the time of her great bereavement, could take the trouble to send us this message. We extend to her our esteem and our sympathy in her loss.

THE EDITOR

---

Edmond F. Cody, M.D.
105 So. Sixth Street
New Bedford, Mass.

R. I. Medical Journal
106 Francis Street
Providence 3, Rhode Island

Dear Sirs:

Dr. Cody died at Sturdy Memorial Hospital, Attleboro, Mass., Feb. 4th, aged 84, of enlarged heart and pneumonia.

Of the many Journals he read so faithfully, I want to tell you, none pleased him more than yours. He may have told you himself, I don't know. However, he never read one without deep appreciation of its dignity.

Yours truly,
s/s DOROTHY L. CODY
(Mrs. Edmond)

## PEDIATRIC ESSAY CONTEST

**In order to stimulate interest in clinical investigation and accurate reporting of pediatric problems, the New England Pediatric Society is offering an award of $200 for the best paper submitted by an intern, resident or fellow. It should deal with one or more pediatric cases, of special interest or significance, with appropriate supporting literature, and discussion. The prize paper will be submitted for publication in the NEW ENGLAND JOURNAL OF MEDICINE.**

**Only doctors connected with a hospital or medical school in New England are eligible to enter, provided they are out of medical school five years or less.**

**The winner of the prize will be announced at the September meeting of the Society.**

**Papers should be submitted before July 31, 1955, to Dr. Harry Shwachman, Secretary of the New England Pediatric Society, 300 Longwood Avenue, Boston 15, Massachusetts.**

# EXTENDING VOLUNTARY MEDICAL CARE COVERAGE IN RHODE ISLAND*

JOSEPH C. O'CONNELL, M.D.

The Author. *Joseph C. O'Connell, M.D., of Providence. President Rhode Island Medical Society Physicians' Service; Past President, The Rhode Island Medical Society.*

WHEN the Rhode Island Medical Society initiated its studies and plans for prepaid voluntary insurance programs more than ten years ago it set forth as objectives its desire to 1) increase the extent to which voluntary insurance against the cost of medical care is made available to the people of the State of Rhode Island, 2) to increase the effectiveness of such insurance through the voluntary cooperation of its members, and 3) to make such insurance available at the lowest practicable cost.

We have just completed the fifth year of our Physicians Service program. It is fitting that we consider how well we have achieved the objectives with which we started our community service to provide surgical-medical insurance in Rhode Island.

An outstanding insurance actuary estimated that the number of persons covered by surgical expense insurance in Rhode Island in 1947 totaled 92,000, and the number covered by medical expense insurance 11,000.

At the end of 1953, the Health Insurance Council of the nine associations in the insurance business reported estimates of 514,000 persons covered by surgical insurance, and 470,000 covered by medical expense insurance. Our Physicians Service, offering a combined surgical-medical protection, accounted for 400,000 of those persons.

To these totals we now can add an additional 42,712 new subscribers who enrolled in our program during 1954, bringing our record for the year to 442,777 persons protected as the result of the action of the physicians of this state in forming Physicians Service.

Our second objective is clearly attained by the fact that 817 physicians, numbering practically all the eligible active physicians in the state, have been listed as participating physicians who guarantee the service features of the contract, and the soundness of the entire program.

Thirdly, we continue once again to set a national low level for operating costs, with only 6.1% of our income allocated to the expense of running this state-wide insurance program. To the subscribers went 90.1% of the income, with the small balance after operating expenses turned into the reserve fund to protect the financial status of Physicians Service.

We have quickly arrived at a leveling off position in our development when we must look to the future for expansion of the service in the interests of the people of Rhode Island. In recent months our schedule of indemnities has been completely reviewed and efforts made to eliminate any inequalities in the previously established fees, and to extend the benefits to aid the greatest number of claimants without increasing the premium charge This action, if carried out as planned, will take approximately $100,000 of the money now allocated annually to the reserve funds, thereby leaving a very small margin to add to surplus.

Our claim load has increased greatly during the past year, and I pay particular tribute to those physicians who have served on our Claims Committee which has weekly reviewed the demands upon the service. Although our enrollment increased by little more than 10% in 1954, the total cases processed for benefits increased by nearly 25%. Undoubtedly we shall soon have to consider the possibility of a medical director to supervise the claims work, and in the immediate future it may be advisable to establish a larger membership for the Claims Committee, or to utilize physicians in the various specialties on a rotating plan to assist in the clarification of claims requests.

It is our hope to offer a new subscriber contract, effective March 1, 1955, with changes in the benefits for surgical operations which will also be reflected in increased benefits to the subscriber, when an assistant surgeon and an anesthetist is required. We will also extend the medical benefits, changing the starting day for payments from the fourth to the third day after hospitalization and extending the payments to a limit of $225, which would repre-

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*An address to the Corporation of the Rhode Island Medical Society Physicians Service at its Sixth Annual meeting, at Providence, Rhode Island, January 26, 1955.

# THE COMMITTEE ON MEDICAL DEFENSE AND GRIEVANCE

ROLAND HAMMOND, M.D.

The Author. *Roland Hammond, M.D., of Providence, Rhode Island. Chairman for eleven years of the Committee on Medical Defense and Grievance of the Rhode Island Medical Society; Past President, Rhode Island Medical Society.*

ELEVEN YEARS' SERVICE as chairman of this important committee of the Rhode Island Medical Society has been a valuable experience from which many useful lessons may be drawn. In retrospect, our committee, one of the first of its kind on a state-wide basis was organized in 1928, in an effort to give to the public and to the medical profession deserving protection.

The previous chairman, the late Dr. Charles F. Gormly, had organized the work of the committee in an orderly program. Here was a situation made to order and patterned for the guidance of future committees. My predecessor, by his tact and ability to inspire confidence, had gained the good will of the medical and dental professions as well as the respect of lawyers, insurance adjusters, the courts and other interested parties.

As the name implies, the committee has two functions, the first of which is to receive and adjudicate complaints by displeased patients concerning conduct, treatment, fees or any other possible reason for discontentment. The second function is to hear and evaluate cases in which legal action against a Fellow of the Society is threatened or is already in progress.

Grievance complaints are brought to the attention of the committee by letters addressed to the Rhode Island Medical Society, to the executive office or directly to the physician. All these communications are carefully and scrupulously investigated. It has been my experience that many complaints are due to misunderstanding, to lack of accurate information or to dissatisfaction with the conduct of the case. Very often, a word carelessly dropped by the attending physician or a solicitous friend may start a train of thought which builds up with the passage of time. Criticism of the physican's fee is probably the origin of most grievance cases. It is interesting to note that most letters stated that the physician should be deprived of his right to practice medicine. How do we approach processing of these problems? After the facts have been assembled, a tactful letter from the committee is usually sufficient to explain the confusion. If this procedure proves unsuccessful, the problem is brought before the full committee for adjudication and disposal. Attempts to bring the complainants before the committee to state their grievance have been rather disappointing. These persons have declined either to follow the recommendations of the committee to which they had previously agreed or have sent notice that they would not press the charges.

In cases of malpractice, action is usually initiated by a letter to the attending physician from the patient's lawyer. As soon as this occurs, the physician reports the circumstances of the case to the executive office of the society or to a member of the committee, and is directed to contact his insurance carrier without delay. It then becomes expedient for the physician to prepare forms listing his qualifications and entire background as well as a complete history of the case. He is further expected to submit his office records, an exact and complete copy of the hospital records, x-ray films when available, and supplementary information from all physicians who have been associated with him in the treatment of the case. When the data is assembled, copies are sent to the individual members of the committee for their study. At a convenient date, a meeting of the committee is called, and the physician as well as the attorney representing the insurance carrier are invited to attend. In some cases, the physician has also retained the services of a personal attorney, and in such an event this attorney is urged to be present. The meeting is held according to parliamentary procedure and the members of the committee sit as a tribunal, hearing a complete recitation of the case by the physician. Examination and cross-examination follow until the case has been meticulously explored. After the evidence and all hypotheses have been fully discussed, the physician and attorney (or attorneys) are excused while the committee deliberates the merits of the case and arrives at a decision. The meeting is then reconvened with the physician and the attorney (or attorneys) returning to the meeting to receive the decision of the

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## MEDICAL DEFENSE AND GRIEVANCE

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committee. In a few cases, where the situation requires highly specialized knowledge, the chairman is instructed to have two or more specialists in attendance so that their opinions will help guide the committee in its final action.

What lessons are to be learned from this wide and illuminating experience? How can the physician-patient relationship be improved? How best to clarify in the public mind the confusion which exists as to the duties and obligations of the medical profession to the public, and conversely the responsibility of the public to cooperate with the medical profession? Articles appearing from time to time in lay papers and magazines fail to contribute to the solution of the problem, but frequently add to the existing confusion. One must conclude that education of the public is necessary and is best accomplished by day-to-day contacts between physician and patients. These heart-to-heart talks will result in clarifying many aspects of the problem which might otherwise remain obscure. Public lectures on medical subjects and radio and TV programs are most valuable media for instruction concerning the nature of a disease and its treatment.

One cannot emphasize too strongly that the physician is under heavy responsibility to his patient or family to explain as fully as his judgment dictates the circumstances and aspects in the individual case. Generally, physicians should never minimize any condition, and the fee situation should be frankly discussed at an early date with responsible parties. Consultations should be held whenever there is any doubt as to the outcome of the illness, or if any evidence of dissatisfaction in the family is detected. Consultations also serve to inspire confidence and in many instances have clarified puzzling or difficult situations. Of inestimable value is another opinion by a qualified expert which often has saved many a practitioner from both professional and legal embarrassment.

It is advisable that the profession be far more circumspect than ever in view of the fact that many law suits are being instituted today, because the public is aware that physicians are now almost universally protected by malpractice insurance. It must be noted also that many patients have no particular grievance against their doctor but this procedure seems to be an easy way to try to collect money.

As a final observation, verdicts in much larger amounts are now being made in the courts than was the practice several years ago. Consequently, it behooves every physician to review his insurance coverage and to be sure that he is adequately protected from financial loss.

## EXTENDING VOLUNTARY MEDICAL CARE COVERAGE IN RHODE ISLAND

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sent physician indemnities for persons hospitalized for as many as fifty-six days.

These developments will carry us to the full limits of our present subscription rates and will use up approximately two-thirds of our annual surplus, leaving a close margin for emergencies. We are one of the few organizations in the entire country that has not increased its charges in the past five years, a truly remarkable tribute to the physicians of Rhode Island who have given their unselfish support to this community program in order to establish it on a solid basis.

We are still reluctant to contemplate a premium increase. But if we are to increase benefits and offer to the people of this state a more comprehensive coverage for their catastrophic illnesses, we must look forward to some increase to guarantee the continued solvency of the program, and the establishment of additional benefits.

Of interest to all of us is the problem of providing a major medical expense protection that would start when either the hospital benefits or the physician's services have been expended under our existing Blue Cross and Physicians Service plans. Our plans were designed to provide families with basic protection for hospital and medical care. However, more and more families have indicated a willingness and a desire to have some insurance against the cost of an extremely serious illness or accident that can result in bills in excess of those likely to be covered by our programs.

This major medical expense type of protection might provide maximum benefits up to $5,000, over and above the base benefits now provided. In general this type of coverage might reimburse the subscriber for ill-health expenses above an amount ranging from $100 to $500 since these deductible amounts are covered by usual policies in most instances. The insured person would be paid a percentage, possibly as much as 75%, of the ill-health expenses he incurs above the deductible amount, and he in turn would agree to pay the remaining per cent.

Whether we can introduce this type of coverage here remains a matter for future consideration. I report it to you at this time because I have named, with the approval of the board of directors, a committee to explore the question with the Hospital Service Corporation of Rhode Island.

The details of the development of Physicians Service in 1954 will be set forth for you in reports of the secretary and the treasurer.

On this occasion I again sincerely thank, both for the medical profession and for the people of the state, the representatives of the public—Messrs. James R. Donnelly, Emil E. Fachon, Walter F. Farrell, John J. Halloran, Felix A. Mirando, and George R. Ramsbottom—for their loyal and conscientious service as members of the board of directors. We are truly indebted to these public spirited citizens for their assistance in making the Rhode Island Medical Society Physicians Service one of the finest programs of its type in the nation.

To our administrative staff and executive officers go our renewed appreciation for jobs well done during 1954.

# Physicians Service Claims...

**For better administration of claims and payments by *Physicians Service*, YOUR HELP is needed.**

**Here are some ways to assist in clearing claims promptly:**

1. ***Ask your patient*** **if he belongs to *Physicians Service* on his first visit to you.**

2. ***Do not advise*** **a patient he is covered under *Physicians Service* unless YOU ARE CERTAIN.**

   **Every subscriber is issued a blue identification card. Ask your patient to show this card to you, and then note the identification number on your records.**

3. ***When submitting your claims*** **be sure that the complete answer is given to every question.**

   **Full names, no abbreviations. Identification number of the subscriber. Diagnosis. Code number from master schedule of indemnities to indicate the procedure for which benefit is claimed. Name of assistant surgeon and anesthetist.**

4. ***File claims PROMPTLY*** **in order that payments may not be delayed to you or the subscriber.**

   **Don't wait until you have an accumulation of claims. Make daily mailings, if possible.**

**RHODE ISLAND MEDICAL SOCIETY**
**PHYSICIANS SERVICE**

# HOUSE OF DELEGATES
## *of the*
# RHODE ISLAND MEDICAL SOCIETY
## *Report of Meeting Held on January 26, 1955*

A MEETING of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library, Wednesday, January 26, 1955. The meeting was called to order by the President, Dr. Henri E. Gauthier, at 8:40 p.m.

The following delegates were in attendance:

*Kent County:* Peter C. Erinakes, M.D.; Edmund C. Hackman, M.D.; Russell P. Hager, M.D. *Pawtucket District:* Francis E. Hanley, M.D.; Edwin F. Lovering, M.D.; Adrien G. Tetreault, M.D.; Henry E. Turner, M.D.; Howard W. Umstead, M.D. *Washington County:* James A. McGrath, M.D. *Providence Medical Association:* Charles J. Ashworth, M.D.; Irving A. Beck, M.D.; Alex M. Burgess, Jr., M.D.; Frederic J. Burns, M.D.; Wilfred I. Carney, M.D.; Francis H. Chafee, M.D.; William B. Cohen, M.D.; Michael DiMaio, M.D.; William J. H. Fischer, Jr., M.D.; John C. Ham, M.D.; Albert H. Jackvony, M.D.; Ernest K. Landsteiner, M.D.; William S. Nerone, M.D.; Arnold Porter, M.D.; Alfred L. Potter, M. D.; William A. Reid, M.D.; Louis A. Sage, M.D.; James J. Sheridan, M.D. *Officers of the RIMS:* Henri E. Gauthier, M.D.; John G. Walsh, M.D.; Frank B. Cutts, M.D.; Thomas Perry, Jr., M.D. *Retiring President of the RIMS:* Earl F. Kelly, M.D. *Woonsocket District:* Alfred E. King, M.D.; Francis P. Vose, M.D. *Delegate to the A.M.A.:* Charles L. Farrell, M.D. *President of Physicians Service:* Joseph C. O'Connell, M.D.

Also present were Mr. John E. Farrell, Executive Secretary, and Dr. Louis I. Kramer, Chairman of the Committee on Diabetes.

### REPORT OF THE SECRETARY

Dr. Thomas Perry, Jr., Secretary, read his report of the actions of the previous two meetings of the Council of the Society, copy of which had been submitted in advance to each member of the House of Delegates. The report follows:

The Council has held two meetings since the last session of the House of Delegates. Among the matters resolved by the Council were the following:

1. Approval was given actions of the President whereby he—

Referred to the Committee on Child Health Relations a request from the Parents Council for Retarded Children of Rhode Island for a meeting to discuss problems of that organization.

Accepted for the Society an invitation for himself and the Executive Secretary to serve as members of a New England local arrangements committee for the Interim Meeting of the American Medical Association to be held in Boston in December, 1955. The Council also authorized the President to pledge the Society's proportionate share towards the expense to be incurred by the medical societies of New England for a dinner for the delegates of the American Medical Association.

Issued a statement during National Nurse Week supporting the efforts of the Rhode Island State Nurses Association to focus attention on the needs of nursing and nursing education.

Arranged for meetings between the Society's Committee on Industrial Health and the new State Workmen's Compensation Commission.

Arranged for a meeting of officers and other representatives of the Society with Dr. Frank Wilson, Director of the Washington Office of the American Medical Association, to discuss national health legislation.

Wrote a letter to the Fellows of the Society explaining in detail the reason for the increase in the annual assessment of dues.

2. The Council notified the Amalgamated Meat Cutters and Butcher Workmen of North America of the interest of the Society in the campaign to secure effective poultry regulation and inspection.

3. It authorized the President to name a representative to attend the annual meeting of the American Medical Education Foundation.

4. It authorized the President to notify the Governor of the State of Rhode Island of the Council's attitudes relative to a regional compact of higher education, particularly noting that a survey of the needs of the state should be first undertaken before legislative commitment is made.

5. It authorized the Executive Secretary to represent the Society at a meeting of the Medical Exhibitors Association in New York.

6. It voted to renew the Society's membership in the National Conference of Presidents and Other Officers of State Medical Associations.

7. It authorized the President to appoint two members of the Cancer Committee to represent the Society, and it further authorized these two members to initiate for the Society the establishment of a proposed Advisory Coordinating Committee for Rhode Island to effect better organization in cancer education and control.

8. It authorized the Secretary to represent the Society at a community meeting to be called to discuss the formation of a United Fund as a solution to the present problem of multiple charitable campaigns.

9. It approved of a recommendation by the Treasurer to transfer the cash reserve of the Frank L. Day Fund to the

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## HOUSE OF DELEGATES

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general account of the Society, but crediting it to the Day Fund. This action will eliminate a separate check book, and deposit record for the Day Fund, and will place it within the pattern adopted for all the other special accounts of the Society.

The Council also approved of recommendations from the Trust Department of the Industrial National Bank relative to changes in some of the investments in the general account administered for the Society by the bank.

10. It approved of a report from the Committee on Professional Relations and Hospitals to be submitted to the House of Delegates.

11. It authorized the President and the Chairman of the Committee on Veterans Affairs to secure, if possible, a delegate to represent the Society at the meeting called by the American Medical Association to be held in February, 1955. It also voted that the Committee on Veterans Affairs explore the possibility of a meeting with leaders of veterans' organizations in Rhode Island to discuss problems relating to the medical care of veterans.

12. It authorized the Trustees of the Medical Library Building to proceed with necessary repairs to the building resulting in the main from hurricane damage.

13. It voted that members in their first year of practice shall be assessed half of the annual dues if elected to membership after June 30, and shall be subject to the full assessment effective January 1 of the ensuing year.

14. It voted that members resuming private practice after a tour of military service shall be exempt from the payment of dues for six months of the year in which they resume private practice.

15. It voted that the Interim Meeting of the Society for 1955 be held on Wednesday, October 26th, at a time and place to be decided by the Committee on Scientific Work and Annual Meeting.

The President briefly commented on the meeting in Boston relative to plans for the Interim Meeting of the American Medical Association to be held in December, 1955.

*Action*—It was moved that the report of the Secretary be approved and placed on file. The motion was seconded and adopted and the report is made part of the official minutes of the meeting.



### *Recommendations of the Council*

The Secretary read the recommendations from the Council, notice of which had been sent to each member of the Society, as follows:

1. The Council recommends to the House of Delegates the nomination of Drs. Charles J. Ashworth and Charles L. Farrell to be the Society's representatives on the Board of Directors of the Hospital Service Corporation of Rhode Island.

*Action*—It was moved that Doctors Charles J. Ashworth and Charles L. Farrell be nominated to serve on the Board of Directors of the Hospital Service Corporation. The motion was seconded and adopted.

2. The Council recommends that the House of Delegates adopt the regulation that no Fellow of the Society shall list his specialty under any condition in the classified section of any telephone or non-medical directory published for use in Rhode Island.

*Action*—After discussion of the recommendation a motion was made that this action be taken and the recommendation be adopted as the policy of the Society. The motion was seconded and passed.

3. The Council recommends that the House of Delegates request the Providence Medical Association to extend to all members of the Society an invitation to attend its meeting on March 7, 1955, to hear Dr. Frank Dickinson, Director of the Bureau of Medical Economic Research of the American Medical Association, discuss the "Retirement Problem of the Doctor"; and further, that subsequent to this meeting on March 7 each district society poll its membership by written ballot, to be supplied by the State Medical Society, listing the issues involved regarding Social Security coverage for physicians, and the summary of such district society polls be reported to the House of Delegates at its meeting in April, 1955.

*Action*—It was moved that the recommendation be adopted. The motion was seconded and passed.

### *Nominations for Medical Members of the Physicians Service Board of Directors*

The Secretary noted that the members of the House had been informed of the present medical roster of the Board of Directors of Physicians Service, the terms of four expiring as of this date.

Dr. Gauthier called for nominations to be made to the Corporation of Physicians Service.

The following were placed in nomination: Charles L. Farrell, M.D., Pawtucket; James C. Callahan, M.D., Newport; Henri E. Gauthier, M.D., Woonsocket; and Hartford P. Gongaware, M.D., Westerly.

*Action*—It was moved that the list of nominations be closed. The motion was seconded and adopted.

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## HOUSE OF DELEGATES

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It was moved that the nominees be submitted to the Corporation of the Rhode Island Medical Society Physicians Service to serve as members of the Board of Directors until the annual meeting of that Corporation in January, 1958. The motion was seconded and adopted.

### *Recess for Physicians Service Meeting*

It was moved that the House of Delegates recess in order that the Corporation of the Rhode Island Medical Society Physicians Service might hold its annual meeting. The motion was seconded and the House recessed at 9:12 p.m., and reassembled at 9:45 p.m.

### *Report of the Delegate to the A.M.A.*

Dr. Charles L. Farrell reviewed the work in general of the House of Delegates of the American Medical Association, and in particular at the recent meeting held in Miami, Florida. He discussed the actions taken by the House, and he stressed the great amount of work that is done by the Committees in the interests of the medical profession.

*Action*—It was moved that the report of the Delegate to the A.M.A. be accepted. The motion was seconded and adopted.

* * *

The president noted that Dr. Farrell was retiring as Delegate after six years of service, and he moved that the House give a rising vote of appreciation to Dr. Farrell for his outstanding work. The motion was seconded and unanimously adopted.

### *Resolutions from District Societies*

The President called for the submission of any resolutions from district societies. There were no resolutions submitted.

### *Report of the Committee on Diabetes*

Dr. Louis I. Kramer, Chairman of the Committee on Diabetes, gave an oral preliminary report on the 1954 Diabetes Detection Campaign conducted by his Committee.

*Action*—It was moved that the report be received. The motion was seconded and adopted.

### *Committee on Professional Relations and Hospitals*

Dr. Charles J. Ashworth reported on the developments for the formation of a local Joint Commission for the Improvement of the Care of the Patient, under the auspices of the Society, the Hospital Association of Rhode Island, and the State Nursing Associations. He reported that his Committee recommended the participation of the Rhode Island Medical Society with this Joint Commission.

*Action*—It was moved that the report of the Committee on Professional Relations and Hospitals be received and its recommendation adopted. The motion was seconded and passed.

### *Committee on Scientific Work and Annual Meeting*

Dr. Earl F. Kelly reported on the preliminary program for the Annual Meeting of the Society to be held in May, 1955, and he read the list of speakers who had accepted invitations to address the Society.

### *Committee on Industrial Health*

In the absence of Dr. Stanley Sprague, Chairman of the Committee on Industrial Health, the Secretary read the recommendations in the report of the Committee, which had been submitted in advance to each member of the House.

*Action*—It was moved that the report of the Committee on Industrial Health and the recommendations relative to the adoption of the "Guiding Principles of Occupational Medicine," and the sending of a questionnaire to the entire membership be approved. The motion was seconded and adopted.

### *Miscellaneous*

The Executive Secretary asked for a ruling regarding the listing on signs by physicians at their office, citing recent experiences regarding problems that have arisen whereby physicians had listed their specialty on their office sign.

*Action*—After brief consideration it was moved that the problem be referred to the Council for its consideration and a report to the House of Delegates with recommendations at the next meeting. The motion was seconded and adopted.

### *Adjournment*

The House was adjourned at 10:30 p.m.

Respectfully submitted,

THOMAS PERRY, JR., M.D., *Secretary*

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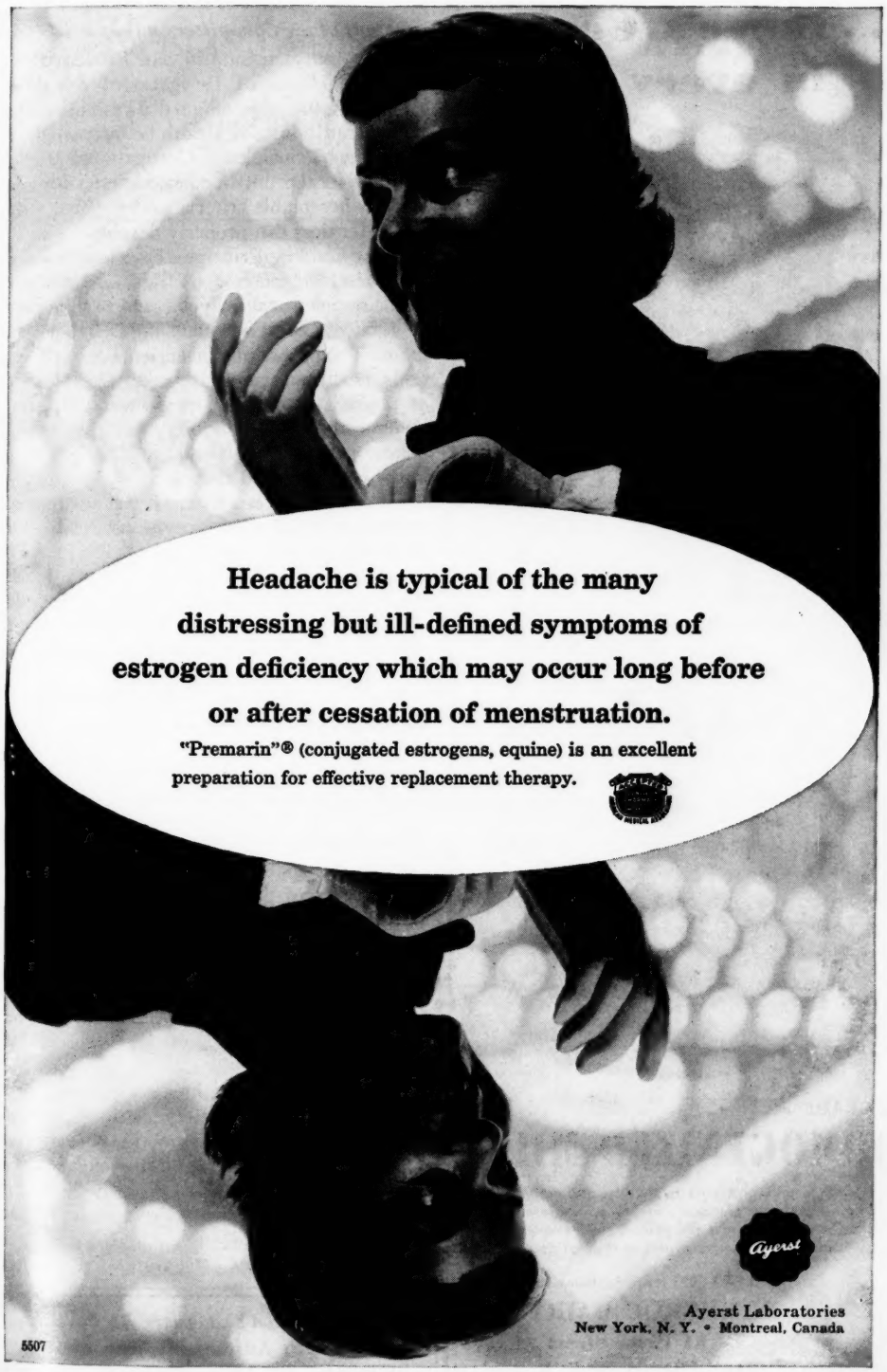
Headache is typical of the many distressing but ill-defined symptoms of estrogen deficiency which may occur long before or after cessation of menstruation.
"Premarin"® (conjugated estrogens, equine) is an excellent preparation for effective replacement therapy.
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## HOUSE OF DELEGATES

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### *Report of the Committee on Industrial Health*

At its annual session in San Francisco in June, 1954, the House of Delegates of the American Medical Association adopted a resolution that the Council on Industrial Health be instructed to refer its Guiding Principles of Occupational Medicine to state and local county medical societies for endorsement as acceptable criteria under which industrial health services can properly develop.

These Guiding Principles have been reviewed by the Society's Committee on Industrial Health. They define occupational medicine and outline the scope of service for an adequate industrial health program. The phases of prevention, medical examinations, health education and counseling, free choice of physician to render medical and surgical care under compensable disability laws, as well as for noncompensable disability, are all briefly set forth in the brochure of Principles.

Of equal importance to us is the incorporation as guiding principles of provisions relative to the professional status of the physician in charge of an industrial medical service, the relationship of the employer and the employee to the industrial physician, and the role of the nurse, consultants, official health and rehabilitation agencies as well as medical organizations.

The Committee on Industrial Health recommends to the House of Delegates the adoption of these Guiding Principles of Occupational Medicine, as set forth by the Council on Industrial Health of the American Medical Association, for all physicians in Rhode Island who may engage in any industrial medical practice.

For some time the Committee has felt the need for a record of the number of physicians engaged in industrial work in Rhode Island, the extent of their work, and the companies providing industrial medical care. From time to time the executive office has received requests for names of physicians interested in engaging in part-time industrial medical work, and a listing of physicians interested should be readily available.

Therefore the Committee requests authorization to send a questionnaire to the entire membership of the Society to secure information that will provide a complete listing of physicians engaged in part-time industrial medical work, as well as a list of men desirous of participating in such programs.

Respectfully submitted,
STANLEY SPRAGUE, M.D., *Chairman*

***SAVE . . . MAY 4 and 5***
**144th Annual Meeting of the**
**RHODE ISLAND MEDICAL SOCIETY**

# RHODE ISLAND MEDICAL SOCIETY PHYSICIANS SERVICE

## *Report of the Sixth Annual Meeting of the Corporation, January 26, 1955*

THE SIXTH Annual Meeting of the Corporation of the Rhode Island Medical Society Physicians Service was held at the Rhode Island Medical Society Library, Wednesday, January 26, 1955. The meeting was called to order by the President, Dr. Joseph C. O'Connell, at 9:12 p.m.

The following members of the Corporation were in attendance:

| | |
|---|---|
| Charles J. Ashworth, M.D. | Earl F. Kelly, M.D. |
| Irving A. Beck, M.D. | Alfred E. King, M.D. |
| Frederic J. Burns, M.D. | Ernest K. Landsteiner, M.D. |
| Wilfred I. Carney, M.D. | Edwin F. Lovering, M.D. |
| Francis H. Chafee, M.D. | James A. McGrath, M.D. |
| William B. Cohen, M.D. | William S. Nerone, M.D. |
| Frank B. Cutts, M.D. | Joseph C. O'Connell, M.D. |
| Michael DiMaio, M.D. | Thomas Perry, Jr., M.D. |
| Peter C. Erinakes, M.D. | Arnold Porter, M.D. |
| Charles L. Farrell, M.D. | Alfred L. Potter, M.D. |
| Wm. J. H. Fischer, Jr., M.D. | William A. Reid, M.D. |
| Henri E. Gauthier, M.D. | Louis A. Sage, M.D. |
| J. Merrill Gibson, M.D. | James J. Sheridan, M.D. |
| Edmund C. Hackman, M.D. | Adrien G. Tetreault, M.D. |
| Russell P. Hager, M.D. | Henry E. Turner, M.D. |
| John C. Ham, M.D. | Howard W. Umstead, M.D. |
| Francis E. Hanley, M.D. | Francis P. Vose, M.D. |
| Albert H. Jackvony, M.D. | John G. Walsh, M.D. |

Also present was Mr. John E. Farrell, Executive Secretary.

### *Annual Report of the Secretary*

Dr. Ernest K. Landsteiner, Secretary, read his annual report, copy of which was submitted to each member of the Corporation. The report is made part of the official minutes of the meeting.

*Action*—It was moved that the report of the Secretary be received and placed on file. The motion was seconded and adopted.

### *Annual Report of the Treasurer*

Dr. Charles J. Ashworth, Treasurer, read his annual report, in which he reviewed the financial status of Physicians Service in 1954, and at the completion of its fifth year of operation. This report is made part of the official minutes of the meeting.

*Action*—It was moved that the report of the Treasurer be received and placed on file. The motion was seconded and adopted.

### *Election of Members to the Board of Directors*

The Secretary reported that the House of Delegates of the Rhode Island Medical Society had nominated, to serve for three-year terms, until the annual meeting of the Corporation in 1958, the following:

Charles L. Farrell, M.D., Pawtucket
Henri E. Gauthier, M.D., Woonsocket
James C. Callahan, M.D., Newport
Hartford P. Gongaware, M.D., Westerly

*Action*—It was moved that the physicians nominated by the House of Delegates be elected by the Corporation. The motion was seconded and adopted.

### *Adjournment*

The business of the Corporation completed, the President declared the meeting adjourned at 9:45 p.m.

Respectfully submitted,
ERNEST K. LANDSTEINER, M.D., *Secretary*

### *Annual Report of the Secretary*

The Board of Directors of Physicians Service has held four meetings during the past twelve-month period to supervise the affairs of the Corporation. In addition the members of the Board have served as active participants on five committees—the Executive Committee, Finance Committee, Professional Advisory Committee, Joint Operations Committee, and Claims Committee. The work of these various committees throughout the year has done much to further the progress of your program.

The Board elected as its officers for the year the following:

Joseph C. O'Connell, M.D. ..... *President*
Rocco Abbate, M.D. ..... *Vice-President*
Ernest K. Landsteiner, M.D. ..... *Secretary*
Charles J. Ashworth, M.D. ..... *Treasurer*

As representatives of the public, the Board re-elected the following:

Mr. James R. Donnelly, Mgr., Pawt. Branch, R. I. Hosp. Trust Co.
Mr. Emil E. Fachon, President, Bulova Watch Company

*continued on next page*

Mr. Walter F. Farrell, Chr., Bd. of Dir., Industrial Nat'l Bank

Mr. John J. Halloran, Commercial Supt., N. E. Tel. & Tel. Co.

Mr. Felix A. Mirando, President, Imperial Knife Company

Mr. George R. Ramsbottom, President, Seekonk Lace Company

A cost analysis was completed during the year of Physicians Service which has been the basis for a revised Joint Operations Agreement effective January 1, 1955.

The problem of payments to non-participating physicians has been subject to review and study, and new assignment to pay forms drafted. The Master Schedule of Indemnities has been reviewed by committees of the Rhode Island Medical Society representing the various specialties, and revisions to eliminate inequalities in the Schedule have been adopted.

The Board authorized the President to name a committee to study the question of long term medical expense, and to consider possible expansions of the Physicians Service program to offer coverage in cooperation with the Blue Cross program of hospitalization.

The membership increased by 42,712 subscribers during the year, continuing Physicians Service as one of the leaders in the nation in enrolling the eligible population in its area.

Appended to this report is a comparative summary of the years 1953 and 1954 as prepared by the Executive Director.

Respectfully submitted,

ERNEST K. LANDSTEINER, M.D., *Secretary*

### *Annual Report of the Treasurer*

*INCOME AND EXPENSES:* Subscription income for the year 1954 totaled $4,089,424.37 compared to $3,345,928.81 in 1953, or an increase of $743,495.56 or 22.22%.

Income on invested funds amounted to $24,672.30 compared to $16,622.71 in 1953, or an increase of $8,049.59.

Surgical-Medical expenses, or amounts paid to physicians in 1954, amounted to $3,707,803.48 compared to $2,984,315.50 in 1953, an increase of $723,487.98 or 24.24%.

Operating expenses in 1954 were $249,817.34 compared to $210,311.60, an increase of $39,505.74 or 18.78%.

The net amount added to reserves for 1954 totaled $156,475.85, compared to $167,924.42 in 1953.

*BALANCE SHEET—DECEMBER 31, 1954.* Rhode Island Medical Society Physicians Service held assets in the amount of $1,820,771.41 compared to $1,549,533.86 a year ago. Cash on hand and in banks totaled $250,612.60; Accounts Receivable, $373,778.90; Investments in Government Bonds, $1,196,379.91; Total Liabilities as of December 31, 1954 totaled $1,302,362.26, compared to $1,099,879.56 a year ago. The Liabilities consisted of Accounts Payable, $341,577.06, Required Accrual for Unreported Cases, $297,723.00, Required Accrual for Maternity Cases, $475,091.00, and Unearned Subscriptions, $187,971.20.

The Reserves as of December 31, 1954 amounted to $518,409.15 compared to $449,654.30 a year ago; an increase of $68,754.85 or 1.7% of the Income for the year.

You can see from the foregoing figures that while the financial soundness of the Plan has been maintained that we really had expenses requiring nearly all of our income.

In regard to reserves—many of our doctors seem concerned that the Corporation has set aside the reserves that we have.

We must bear in mind that we now have a Plan in which 442,777, or 56% of the citizens of our State are members. We are therefore obligated to provide protection for them in the form of surgical-medical benefits in accordance with the terms of a contract which they have purchased. The Directors of your Corporation, as well as the Insurance Commissioner of the State of Rhode Island, (through his supervision) are charged with the responsibility of operating the Plan so that the best interests of the public will be served. This means the ability to pay claims to subscribers or participating physicians promptly.

It is therefore required that an accrual be maintained at all times equivalent to the maternity claims paid for the last nine months. These now total $475,091.00. The Insurance Commissioner has also required us to set up a Statutory Reserve of $300,000.00 to take care of any unusually heavy demand that might be placed on the Corporation. This leaves only $218,409.15 unallocated in our reserves to carry us over any period where expenses exceed income, as they do in several months during each year, and as they probably will to a greater extent during the year 1955. We have only about two (2) months of medical-surgical expenses in our reserves; whereas the Blue Shield Plan in Massachusetts has 5.7 months in reserve, Connecticut 4.1 months, and the average of 23 Blue Cross plans our size have 3.8 months.

In view of this it may be necessary in the future to build reserves more adequately than they are at present. I am sure that we all want our plan to continue to operate on the same sound basis that has been maintained since it started.

CHARLES J. ASHWORTH, M.D., *Treasurer*

***Rhode Island Medical Society Physicians Service—Comparative Data***

| | *Year 1953* | *Increase or (Decrease)* | *Year 1954* |
|---|---|---|---|
| Subscribers | 400,065 | 42,712 | 442,777 |
| % Blue Cross Direct Payment Members Enrolled | 58.7% | 7.1% | 65.8% |
| % Blue Cross Group Members Enrolled | 68.9% | 8.1% | 77.0% |
| % State's Eligible Population Enrolled | 50.5% | 5.4% | 55.9% |
| Number of Firms Buying Physicians Service | 575 | 106 | 681 |
| Amount Paid to Participating Physicians | $2,486,094.49 | $625,025.51 | $3,111,120.00 |
| Amount Paid to Non-Participating Physicians: | | | |
| In State | | | $268,506.00 |
| Out of State | | | $328,177.48 |
| Total | $498,221.01 | $98,462.47 | $596,683.48 |
| Total Paid to Physicians Since Start of Plan | $7,076,757.11 | $3,111,120.00 | $10,187,877.11 |
| Number of Participating Physicians | 810 | 7 | 817 |
| Total Assets | $1,549,533.86 | $271,237.55 | $1,820,771.41 |
| Investments | $896,504.91 | $299,875.00 | $1,196,379.91 |
| Total Income | $3,362,551.52 | $751,545.15 | $4,114,096.67 |
| Total Reserves | $449,654.30 | $68,754.85 | $518,409.15 |
| Reserve for Maternity Benefits | $387,370.00 | $90,721.00 | $478,091.00 |
| Operating Expenses | $210,311.60 | $39,505.74 | $249,817.34 |
| Operating Expenses per Subscriber | $.618 | ($.011) | $.607 |
| % Income for Operating Expenses | 6.2% | (0.1%) | 6.1% |
| % Income for Claims | 88.8% | 1.3% | 90.1% |
| Total Cases Processed | 80,393 | 18,747 | 99,140 |
| Maternity Cases* | 7,708 | 1,580 | 9,288 |
| Number of Months Expenses in Reserve | 3.1 Mos. | (0.1) | 3.0 Mos. |
| Massachusetts Blue Shield | | | 5.7 Mos. |
| Connecticut Medical Service | | | 4.1 Mos. |
| Average of 23 Blue Shield Plans our Size | | | 3.8 Mos. |

*Included in Total Cases
January, 1955

## WHAT MAKES A GOOD HOSPITAL?

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search may be considered minimum, there should be someone who is interested in seeing that the important unusual case, which can occur in the small hospital as well as in the large one, is recorded in the literature.

Another important committee is the Tumor Board, a group on which several services are represented, whose function it is to render a composite opinion as to the proper diagnosis and treatment in all patients in whom neoplasms are suspected or observed. Such a Board usually acts in a consultative capacity in the case of inpatients, but may also serve as a definite treatment group in dealing with outpatients.

So much for activities of the active staff as a whole. Many other committees and similar groups can be formed as the need arises. A Journal Club, for example, in which members of the active, resident, and often consulting or associate staff cooperate in covering recent medical literature can be, if properly carried on, a great asset.

I have said nothing definite about departmentalization of the active staff. This is of course desirable in the larger hospitals with the various subspecialties represented as autonomous services, or as parts of the major divisions—medical and surgical. Each of these sections or services should have a chief, and their functions and sphere of activity should be clearly defined. They should have their own meetings and conferences and keep records of them.

One other matter should be considered: Consultations. The new Standard on this subject reads as follows: STANDARD—REQUIRED—II B 3

"Except in emergency, consultation with another qualified physician shall be required in all first Caesarean sections and in all curettages or other procedures by which a known or suspected pregnancy may be interrupted. The same requirement shall apply to operations performed for the sole purpose of sterilization on both male and female patients. Included in consultations required under this Standard are all those which are required under the rules of the hospital staff.

"In major surgical cases in which the patient is not a good risk, and in all cases in which the diagnosis is obscure, or when there is doubt as to the best therapeutic measures to be utilized, consultation is appropriate. Obviously, judgment as to the serious nature of the illness and the question of doubt as to diagnosis and treatment rests with the physician responsible for the care of the patient. It is the duty of the hospital staff through its chiefs of service and executive committee to see that members of the staff do not fail in the matter of calling consultants as needed. A consultant must be well qualified to give an opinion in the field in which his opinion is sought.

"A satisfactory consultation includes examination of the patient and the record and a written opinion signed by the consultant, which is made part of the record. When operative procedures are involved, the consultation note, except in emergency, should be recorded prior to operation."

This Standard is believed to have met the criticisms leveled at the previous one which it replaces. Several of those who were most dissatisfied with the previous wording have expressed the opinion that it is now fully satisfactory. An explanatory note including a more complete definition of terms will be published in the BULLETIN OF THE COMMISSION, and elsewhere.

Of course, the active medical staff is but a part, albeit a most important part, of the medical team that runs the hospital. The nursing staff is another, and, in addition, we have social service, dietetics, engineering, etc.,—all of primary importance. For the proper organization and functioning of these divisions, adequate standards have been established; but these are beyond the scope of this communication as they are, for the most part, beyond the competence of the writer. Their excellence, as is the case with the medical staff, depends upon the basic quality of the people who run them. In general, it is the experience of the Joint Commission that hospitals are manned by superior people with high ideals and enthusiasm. The surveys show that throughout the country the work on the whole is being well done; and it is, for the most part, the duty and privilege of the commission to size up the situation in each hospital and to point out where improvement can be made in this detail or that. It is hard to imagine an instance in which, in such a complicated and detailed organization as a modern hospital, no chance for improvement can be found. The almost infinite number of details that should be considered is well illustrated in an article in HOSPITALS (Part II, June 1954) in which there are listed no less than 404 questions that can be asked of the administrator and staff in the process of investigating a hospital. (Of these, 115 pertain to the medical staff and 61 to medical records.) The encouraging fact is that in most instances in the development and functioning of the hospital under the supervision of clear-sighted, earnest trustees, a good administrator and a competent staff, these questions will—with very few exceptions—all have been answered correctly before they are asked.

This brings us back to the basic query and its answer, with which we began this discussion. The question is this: "What makes a good hospital?" The answer is "Good people."

## CORRESPONDENCE ON CARBON DIOXIDE THERAPY ARTICLE

January 21, 1955

Dear Doctor Chase:

You published an article on Carbon Dioxide Therapy, by Laurence A. Senseman, M.D., in the July issue of the JOURNAL.

Lawrence Spielberger, M.D., in a letter written to the editor and published in the October issue, commented on Dr. Senseman's article and gave warning with respect to certain complications which might arise during the application of the carbon dioxide treatment, namely, and I quote:

"1. The stage of excitement with its high reflex irritability, particularly in the absence of premedication.

"2. Vomiting and aspiration.

"3. Respiratory obstruction."

Apparently, Dr. Spielberger has never used the carbon dioxide treatment himself and, therefore, his warning is justified on a hypothetical assumption. When experimenting with this somewhat novel method of treatment during the years 1943 through 1947, I had exactly the same misgivings and apprehensions—to the extent that during my experiments I requested the presence of an expert in resuscitation just in case any one of the above-mentioned complications might arise.

It took me four years of experimentation, during which I produced about 10,000 narcoses and anaesthesias by using a mixture of 30% carbon dioxide and 70% oxygen, to dispel my anxiety about such complications. Only after I became convinced that no vomiting and aspiration, nor respiratory obstruction or embarrassment, did occur during the four years of experimentation with the gas, did I publish the method in 1947. Since then, about 300 psychiatrists and quite a few general practitioners have been using the carbon dioxide treatment in this country. Furthermore, the method is used in France, Italy, Germany, Switzerland, England, Australia, Canada, South Africa, Japan and India. I would say, as a fair estimate, that over one-half million anaesthesias have been produced by using carbon dioxide in these countries as well as the United States and not one of Dr. Spielberger's complications have been reported. Therefore, we might state, with an almost 100% probability, that in spite of my own apprehensions and the justified warning of Dr. Spielberger, which is based on theoretical considerations, the practice, fortunately, has not borne out our assumptions. The method should, therefore, be considered to be safe in the hands of a properly trained physician.

I would greatly appreciate it if you would publish this letter in your JOURNAL.

Sincerely yours,

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University of Illinois College of Medicine,
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## RECENT ADVANCES IN THE MANAGEMENT OF SEVERE AND EXTENSIVE BURNS

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Other adjuncts in the treatment of burns are the recognized antibiotics, blood transfusions, plasma, high protein and carbohydrate diet with increase of vitamin intake. The most important complications of severe burns have been enumerated and briefly discussed.

### BIBLIOGRAPHY

[1]Liebow, Averill; Warren, Shields; DeCoursey, Elbert: Pathology of Atomic Bomb Casualties, Am. J. Path. 25:853, 1949
[2]Riehl, G.: Treatment of Severe Burns by Blood Transfusions, Wien. klin. Wchnschr. 38:833, 1925
[3]Management of the Cocoanut Grove Burns at Massachusetts General Hospital, Ann. Surg. 117:801, 1943
[4]Brown, W. A.; Farmer, A. W.; Franks, W. R.: Local Application of Aluminum Foil and Other Substances in Burn Therapy, Am. J. Surg. 76: 594, 1948
[5]Young, Forrest: Immediate Skin Grafting in the Treatment of Burns; A Preliminary Report, Ann. Surg. 116:445, 1942
[6]Mason, Michael: The Treatment of Burns with Particular Reference to Local Care, Indust. Med. 18:59, 1949
[7]Blocker, T. G., Jr.; Pomerat, C. N.; Lewis, S. R.: Research Opportunities with the Use of Cultures of Living Skin, Plast. & Reconstruct. Surg. 5:283, 1950
[8]Olson, W. H.; and Necheles, H.: Studies on Anuria: Effect of Infusion Fluids and Diuretics on the Anuria Resulting from Severe Burns, Surg., Gynec. & Obst. 84:283, 1947
[9]Blocker, T. G., Jr.: Present Status of Treatment of Severe Burns, Texas Rep. Biol. & Med. 7:484, 1949
[10]Blocker, T. G., Jr.; Hendrix, J. H.: Persistence of Homograft Tissue Beyond the Usual Survival Period: A Case Report. In press.
[11]Kyle, M. J.; Wallace, A. B.: The Exposure Method of Treatment of Burns, Brit. J. Plast. Surg. 3:144, 1950

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